Supreme Court, U.S.
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No. 99-936

In the

Supreme Court of the United States

CRYSTAL M. FERGUSON, *et al.*,
Petitioners,

v.

THE CITY OF CHARLESTON,
SOUTH CAROLINA, *et al.*,
Respondents.

On Petition for A Writ of Certiorari To The
United States Court of Appeals For The Fourth Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED FOR REVIEW

Whether the Fourth Amendment special needs doctrine was properly applied to drug tests performed by the MUSC Medical Center for treatment of prenatal substance abuse by their maternity patients?

TABLE OF CONTENTS

Page

Question Presented for Review i

Table of Authorities iii

STATEMENT OF THE CASE 1

I. Introduction 1

II. Development of the MUSC Medical Center Policy 2

A. Evidence of a Medical Epidemic 3

B. Development of the Policy 4

III. The Policy for Management of Drug Abuse During Pregnancy 6

IV. Effectiveness of the Policy 7

V. Procedural History 8

REASONS FOR DENYING THE WRIT 9

I. The Basic Tenet of the Fourth Amendment is Reasonableness. 10

II. The Principles and Parameters of the Special Needs Doctrine are Clearly Established by Supreme Court Precedent 11

III. The Special Needs Doctrine was Properly Applied To the MUSC Medical Center Maternity Policy. 17

A. There was a Well-Documented Special Need to Protect Pregnant Patients and their Children. 17

B. MUSC's Interest in Protecting the Health of their Maternity Patients and their Children Outweighed the Minimal Intrusion on the Patients' Diminished Expectations of Privacy. 21

IV. The Decision of the Court of Appeals is Not in Conflict with the Decisions of Other Circuits. 23

V. There are Alternate Independent Grounds to Sustain the Finding of No Fourth Amendment Violation. 27

A. The Petitioners consented to the drug tests. 27

B. The MUSC Medical Center staff were not state actors subject to the strictures of the Fourth Amendment. 28

CONCLUSION 29

TABLE OF AUTHORITIES

Cases — Page

Almeida Sanchez v. United States,
413 U.S. 266 (1973) 10

Aubrey v. School Bd. of Lafayette Parish,
148 F.3d 559 (5th Cir. 1998) 24

Bluestein v. Skinner,
908 F.2d 451 (9th Cir. 1990),
cert. denied, 498 U.S. 1083 (1991) 24

Camara v. Municipal Court,
387 U.S. 523 (1967) 11

Chandler v. Miller,
520 U.S. 305 (1997) 16, 18

Darryl H. v. Coler,
801 F.2d 893 (7th Cir. 1986) 26

Dimeo v. Griffin,
943 F.2d 679 (7th Cir. 1991) 24

Franz v. Lytle,
997 F.2d 784 (10th Cir. 1993) 25, 26

Griffin v. Wisconsin,
483 U.S. 868 (1987) 12, 13, 20

International Bhd. of Elec. Workers,
Local 1245 v. U.S. Nuclear Regulatory Comm'n,
966 F.2d 521 (9th Cir. 1992) 24

Michigan Dept. of State Police v. Sitz,
496 U.S. 444 (1990) 23

National Treasury Employees Union v. Von Raab,
489 U.S. 656 (1989) 13

New Jersey v. T.L.O.,
469 U.S. 325 (1985) 10, 11, 12, 18

Penny v. Kennedy,
915 F.2d 1065 (6th Cir. 1990) 24

Schaill v. Tippecanoe County School Corp.,
864 F.2d 1309 (7th Cir. 1989) 24

Schmerber v. California,
384 U.S. 757 (1966) 22

Schneckloth v. Bustamonte,
412 U.S. 218 (1973) 27

Skinner v. Railway Labor Executives' Association,
489 U.S. 602 (1989) 13, 14, 15, 19

Solid Waste Dep't Mechanics v. City of Albuquerque,
156 F.3d 1068 (10th Cir. 1998) 24, 25

Stigile v. Clinton,
110 F.3d 801 (D.C. Cir. 1997),
cert. denied, 522 U.S. 1147 (1998) 24

Todd v. Rush County Schools,
133 F.3d 984 (7th Cir. 1998),
cert. denied, 119 S.Ct. 68, 142 L.Ed.2d 53 (1998) 24

Transport Workers' Union of Philadelphia, Local 234 v. Southeastern Pennsylvania Transp. Auth., 884 F.2d 709 24

United States v. Attson, 900 F.2d 1427 (9th Cir.), cert. denied, 498 U.S. 961 (1990) 28

United Teachers of New Orleans v. Orleans Parish School Board, 142 F.3d 853 (5th Cir. 1998) 24

Vernonia School District 47J v. Acton, 515 U.S. 646 (1995) 15, 23

Wildauer v. Frederick County, 993 F.2d 369 (4th Cir. 1993) 25

Willner v. Thornburgh, 928 F.2d 1185 (D.C. Cir. 1991), cert. denied, 502 U.S. 1020 (1991) 24

STATEMENT OF THE CASE

I. Introduction

This case involves a constitutional challenge to a policy established by the Medical University of South Carolina Medical Center for "Management of Drug Abuse During Pregnancy." Pursuant to the Policy, the medical staff performed urine drug screens on pregnant patients who presented certain specified medical symptoms and criteria indicative of drug abuse.

The Petitioners are ten women who sought treatment at the Medical Center during their pregnancies and were identified as potential drug abusers. With their consent, the medical staff conducted urine tests as part of their medical care and treatment that ultimately revealed evidence of cocaine use. Thereafter, the Petitioners brought this Section 1983 claim asserting that the urine test performed for medical purposes was a warrantless search in violation of the Fourth Amendment.

The Petitioners' claims were rejected by the trial jury and by the Court of Appeals on different grounds, each of which is fully justified by the law and the evidence. The trial jury found that the Petitioners consented to the tests. Without questioning the sufficiency of the evidence to support the trial jury's finding of consent, the Court of Appeals correctly ruled that the searches were reasonable under the special needs doctrine as enunciated by this Court. 186 F.2d 469 (4th Cir. 1999).

The Medical Center presented evidence that the urine drug screens were medically necessary for management of pregnancy patients and the newborns. The Medical Center also presented documented evidence of an epidemic of cocaine use among its maternity patient base and the

consequent public health problems and associated fiscal costs. The clinical necessity for the drug screens, the health problems associated with maternal cocaine use, and the astronomical economic costs of caring for infants suffering from the effects of cocaine use by their mothers all created special needs beyond normal law enforcement goals. On the other hand, the urine testing policy was a minor intrusion of the Petitioners' privacy expectations inasmuch as their urine was collected and tested in the regular course of medical treatment to which they had consented. In the balance, the Medical Center's special interest in protecting the health of its pregnant patients and their children significantly outweighed the minimal intrusion suffered by the Petitioners. Therefore, the searches conducted were reasonable and did not violate the Fourth Amendment.

Accordingly, there are no compelling reasons for this Court to grant the petition for a writ of certiorari. The special needs doctrine has been well-defined in a number of decisions and the application of that doctrine in this case is not in conflict with the controlling precedent of this Court or any relevant decision of any other court of appeals.

II. Development of the MUSC Medical Center Policy

The Petitioners have misstated the facts regarding the purpose and goal behind development of the Policy. It was not, as the Petitioners assert, designed and implemented to gather evidence to prosecute the Petitioners. The Policy was developed and implemented to promote the health and well being of maternity patients and their unborn children.

A. Evidence of a Medical Epidemic

The Petitioners cannot dispute that there was a documented problem with prenatal drug abuse. In the late 1980s, research studies and medical literature were published showing that there was a national epidemic of illegal drug abuse with staggering associated social and economic costs.

Each year in South Carolina, alone, approximately 15,000 babies suffered from prenatal exposure to illegal drugs. [App. 73] Of those, as many as 3,221 pregnant women, were using cocaine. [App. 74] The medical staff at MUSC observed the effects of the epidemic through their own clinical observations. [App. 34, 46]

The use of cocaine can have serious consequences for maternal and infant health. Effects on the mothers include, increased risk of premature delivery, premature separation of the placenta (abruptio placentae), and spontaneous abortion. [App. 76] Cocaine use during pregnancy can affect infants in a number of ways, including an increased risk of sudden death syndrome, low birth weight, seizures, strokes, heart attacks, lack of bonding, emotional disorders, behavioral problems, and learning disabilities. [App. 75] Other medical problems suffered by these infants include: brain damage, prune belly syndrome, limb reduction defects, kidney damage, and damage to the genitourinary and reproductive systems. [App. 4-6] In some cases, even a single dose of cocaine can kill the baby and the mother too. [App. 10]

The potential complications with the pregnancy and delivery make it clinically necessary for the obstetrical staff to know whether the mother has used cocaine. [App. 47] The pediatric staff also need to know if a newborn has tested positive for drug use because their management of newborns

can be affected by possible withdrawal or other manifestations of prenatal drug abuse. [App. 3-4, 49]

In addition to the potentially devastating harm suffered by the pregnant women and their children, prenatal cocaine use also produces staggering societal costs – increased need for neonatal intensive care at birth, increased needs for social services, foster care, and special education services, lower levels of achievement of educational and occupational goals, increased family stress, and reduced maternal bonding. [App. 76] The national costs to care for cocaine exposed infants were estimated to rise as high as $3 billion annually. [App. 28-29] The medical costs for each infant can exceed $50,000 for the first year alone. Severe exposure can result in lifetime economic costs in excess of $ 1 million per infant. [App. 77]

B. Development of the Policy

When the MUSC medical staff observed that the national epidemic had reached Charleston, they established a protocol in April 1989 for the routine diagnosis of their patients. Because of concerns about the degree of discretion in allowing individual physicians to order urine drug tests, they established six criteria to control the discretion. Any MUSC maternity patient presenting one or more of these criteria was automatically tested. If a patient tested positive, she was referred to the county substance abuse commission for counseling and treatment. However, this protocol proved to be ineffective when virtually none of the patients referred followed through with treatment. [App. 36-37, 67]

Faced with a crisis and lack of success with the voluntary referral protocol, the Medical Center was still in need of an effective policy. After hearing media publicity about a

policy being implemented in the upstate, the case manager for the obstetrics department mentioned it to the Medical Center's General Counsel who in turn contacted the Charleston County Solicitor.

In the fall of 1989, a multidisciplinary task force was formed, consisting of members of the MUSC medical staff, the Solicitor's Office, the Charleston County Police Department, the Department of Social Services, and the Charleston County Substance Abuse Commission. [App. 29-30] Every person involved in that task force had one overriding objective – to develop an effective policy that would discourage prenatal cocaine abuse and protect infant and maternal health: "This was not supposed to be a punitive policy where we went out and punished people for doing something, even though we knew the activity was illegal. What we were trying to do is give those babies a change to be born normal." [App. 33]

Since the voluntary referral protocol had proven ineffective, the task force determined that any chance of success would depend on some coercive factor. The substance abuse representative on the task force supported the "carrot and stick" method of coercive treatment as a last resort in dealing with the problem. He explained that most addicts are in such a state of denial that they will not voluntarily seek help unless there is some leverage to get their attention. [App. 39-43] The Policy ultimately established provided a three-step process for dealing with pregnant patients that tested positive. The first two steps paralleled the prior protocol, but the addition of a third step – threat of law enforcement intervention – provided the necessary "leverage" to make the Policy effective.

III. The Policy for Management of Drug Abuse During Pregnancy

The first step in the implementation of the Policy was the identification of pregnant patients suspected of drug abuse. The Policy contained a list of medical symptoms and indicia of drug abuse to identify which patients were to be screened by urine testing, to wit: 1. No prenatal care; 2. Late prenatal care after 24 weeks gestation; 3. Incomplete prenatal care; 4. Abruptio placentae; 5. Intrauterine fetal death; 6. Preterm labor of "no obvious cause"; 7. IUGR of "no obvious cause"; 8. Previously known drug or alcohol abuse; or 9. Unexplained congenital anomalies.[1] [PA 53-54[2].]

Like all MUSC patients, the maternity patients signed consent forms permitting the medical staff to conduct necessary testing – including urine tests.[3] In addition, all maternity patients were provided with educational information about the harmful effects of prenatal drug abuse and each patient also signed a statement acknowledging that she had received counseling.

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[1] This list was not "medically senseless" as the Petitioners contend. Rather, the list was compiled by the Medical Center physicians from the medical literature available at the time. Nor was the list targeted to discriminate against African-American pregnant women. To the contrary, the list was developed to remove any discretion for testing. [App. 46, 49]

[2] References to the Appendix submitted by the Petitioner's will be designated as "PA."

[3] See forms, App. 60-65. The Petitioners claim that they did not give consent for their urine to be tested for drugs. The jury, however, found that they did consent. See discussion, infra.

If a patient tested positive, the second step included providing the patient with the same educational information and referring her to substance abuse counseling. If the patient failed to follow-up with substance abuse treatment or prenatal medical visits, or if she tested positive a second time, the Solicitor's office was notified and arrests were made.[4] This new third step proved to the pivotal factor in making this an effective policy.

IV. Effectiveness of the Policy

Contrary to the Petitioners' broad assertions, the record establishes that the Policy was highly effective in educating women of the dangers and in discouraging cocaine use during their pregnancies.[5] After implementation of the Policy, the medical staff experienced a decline in the number of positive drug screens and fewer medical complications previously attributed to cocaine abuse. [App. 38, 67-68] The substance abuse counselors reported that many of the patients referred by MUSC benefited from and successfully completed the treatment. [App. 11] Even many of the Petitioners themselves admitted that the Policy helped them successfully complete treatment and fight their addictions. [App. 1-3]

Of the 253 patients who tested positive during the relevant time period, only thirty failed to complete treatment or tested positive a second time and consequently, were arrested. Of

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[4] During a short period of time when the Policy was first initiated, a positive test was immediately reported and the patient was arrested. In early 1990, the Policy was amended to provide the patients a chance to obtain substance abuse treatment and avoid arrest. Even after arrest, the patient could avoid prosecution by completing a drug treatment program.

[5] The Policy has been discontinued since this litigation was initiated.

those thirty, most were processed through pretrial intervention upon voluntary completion of substance abuse treatment. Only two – neither of whom is a Petitioner – failed to complete treatment and were prosecuted, but even they were ordered to complete treatment as a condition of probation rather than sentenced to an active jail term. [App. 79-80]

Contrary to the Petitioners' supposition, there was no evidence that the Policy discouraged pregnant women from seeking treatment at the Medical Center. [App. 67]

V. Procedural History

In addition to the Fourth Amendment claim, the Petitioners asserted a number of federal and state law claims, each of which was properly rejected by the District Court, the trial jury, and the Court of Appeals after a six-week trial.[6]

The District Court submitted the Fourth Amendment claim to the jury on the question of whether the Petitioners consented to the urine drug tests, and judgment was entered

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[6] In addition to the Fourth Amendment challenge, the Petitioners asserted a constitutional challenge to the disclosure of medical information to law enforcement personnel as a violation of their Fourteenth Amendment right to privacy and a statutory claim for racial discrimination in violation of Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. §§ 2000d - 2000d-6; the Petitioners also asserted a state-law tort claim against the MUSC medical staff for abuse of process. The District Court granted judgment as a matter to law to the Defendants on the claims of abuse of process and right to privacy. The jury found that the Defendants had not intentionally discriminated against the Plaintiffs based on their race, and the District Court ruled for the Defendants on the Title VI disparate impact claim. The Court of Appeals affirmed the District Court findings on abuse of process, right to privacy, and disparate impact.

for the Defendants on the jury's finding that the Petitioners had consented to the searches. On appeal, rather than address the sufficiency of the evidence to support the jury's finding of consent to the urine tests, the Court of Appeals found that the searches were reasonable under the special needs doctrine and affirmed the judgment for the Defendants.

REASONS FOR DENYING THE WRIT

This Court has clearly established the guiding principles and parameters of the special needs doctrine in a number of opinions. The Court has recognized that in certain cases, the government may have "special needs," beyond normal law enforcement goals, which make the usual warrant and probable-cause requirement impracticable. In those special needs cases, the reasonableness of the search is measured by balancing the government's interest against the individual's privacy expectations.

The application of the special needs doctrine to the MUSC Medical Center Policy is not, as the Petitioners contend, a radical extension of the special needs doctrine. The Policy is clearly sustainable as a reasonable search under the special needs doctrine as enunciated by this Court's precedent.

The Court of Appeals recognized that the special needs doctrine only applies where there is a compelling or important special need founded on a concrete – not symbolic or hypothetical – danger. The Court of Appeals also acknowledged that the ultimate reasonableness of the search must be evaluated by balancing the public interest and the effectiveness of the search in advancing that interest against the individual privacy expectations and the degree of intrusion suffered by the individuals.

In upholding the MUSC Policy, the Court of Appeals correctly applied the principles and adhered to the parameters set by this Court. The evidence demonstrated that the drug screens were medically necessary for the treatment of the maternity patients and their children and that the epidemic of cocaine use by pregnant women and the attendant public health problems created a special need beyond normal law enforcement goals. The evidence also established that the MUSC urine testing policy was effective in addressing that special need and that the intrusion on the Petitioners' privacy expectations was minimal. Therefore, the Court of Appeals properly found that the searches were reasonable.

I. The Basic Tenet of the Fourth Amendment is Reasonableness.

The Fourth Amendment does not require that all searches be conducted pursuant to a warrant supported by probable cause.[7] Rather, "[t]he fundamental command of the Fourth Amendment is that searches and seizures be reasonable, and although 'both the concept of probable cause and the requirement of a warrant bear on the reasonableness of a search ... in certain limited circumstances neither is required.'" *New Jersey v. T.L.O.*, 469 U.S. 325, 340 (1985) (quoting *Almeida Sanchez v. United States*, 413 U.S. 266, 277 (1973)).

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[7] The Fourth Amendment only imposes strictures on government action. The Respondents have maintained through the litigation that the Medical Center and its staff were not state actors in conducting clinically necessary drug screens. See discussion infra.

The touchstone of Fourth Amendment analysis is reasonableness and "what is reasonable depends on the context within which a search takes place:"

> The determination of the standard of reasonableness governing any specific class of searches requires "balancing the need to search against the invasion which the search entails." On one side of the balance are arrayed the individual's legitimate expectations of privacy and personal security; on the other, the government's need for effective methods to deal with breaches of public order.

Id. at 337 (quoting *Camara v. Municipal Court*, 387 U.S. 523, 537 (1967)). The special needs doctrine comprises one such category of searches, which are valid notwithstanding the lack of a warrant or probable cause.

II. The Principles and Parameters of the Special Needs Doctrine are Clearly Established by Supreme Court Precedent.

The genesis of the special needs doctrine is found in the decision of *New Jersey v. T.L.O.*, supra, in which the Court addressed the proper standard for assessing the legality of searches conducted by public school officials. In that case, a school principal discovered marijuana and other paraphernalia while searching a student's purse for cigarettes. When the principal turned the evidence over to the police and the state brought delinquency proceedings, the student moved to suppress the evidence, contending that the principal had violated her Fourth Amendment rights.

In upholding the search, the Court found that the warrant requirement was unsuited to the school environment and

concluded that the school officials did not need to obtain a warrant before searching students under their authority. The Court also concluded that the school officials did not need probable cause to believe a violation of law has occurred; but rather, that "the legality of a search of a student should depend simply on the reasonableness, under all the circumstances, of the search. *Id.* at 341.

Justice Blackmun concurred in the judgment of the Court, but wrote separately to emphasize the predicate justification for a warrantless search without probable cause: "Only in those exceptional circumstances in which special needs, beyond the normal need for law enforcement, make the warrant and probable-cause requirement impracticable, is a court entitled to substitute its balancing of interests for that of the Framers." *Id.* at 351.

The Court adopted Justice Blackmun's special needs analysis in *Griffin v. Wisconsin*, 483 U.S. 868, 873-74 (1987), in holding that a state's operation of a probation system constitutes "'special needs' beyond normal law enforcement that may justify departures from the usual warrant and probable-cause requirements." [8] Pertinent to the Court's analysis was the fact that the probation officer who conducted the search was not a law enforcement officer; but rather, a government employee charged with supervising his client with the goal of assuring that the probation served as a period of genuine rehabilitation.

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[8] The Petitioners attempt to categorize this case and the other probation/parole cases separate from "special needs" cases on the grounds that probationers/parolees have lesser liberty rights. However, a fair reading of the Court's opinion shows that the decision was based squarely on the special needs doctrine.

The Court further refined the special needs doctrine in the companion cases of *Skinner v. Railway Labor Executives'* Association, 489 U.S. 602 (1989), and *National Treasury Employees Union v. Von Raab*, 489 U.S. 656 (1989), which presented two different drug test policies for review under the special needs doctrine.

At issue in *Skinner* were railroad company policies that required blood, breath and urine testing of its employees under certain circumstances as required or permitted by regulations of the Federal Railroad Administration.[9] The Court found that "[t]he Government's interest in regulating the conduct of railroad employees to ensure safety, ... 'likewise presents 'special needs' beyond normal law enforcement that may justify departures from the usual warrant and probable-cause requirements.'" 489 U.S. at 620 (quoting *Griffin v. Wisconsin*, supra at 873-74).

In *Von Raab*, the Court upheld a policy of the United States Customs Service requiring a urinalysis test from all employee applicants for transfer or promotions to certain positions. In so holding the Court succinctly articulated the following two-step analysis for application of the special needs doctrine: "[W]here a Fourth Amendment intrusion serves special governmental needs, beyond the normal need for law enforcement, it is necessary to balance the individual's privacy expectations against the Government's interests to determine whether it is impractical to require a warrant or some level of individualized suspicion in the particular context." 489 U.S. at 665-66.

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[9] The regulations had been promulgated after the FRA gathered and evaluated evidence that on-the-job intoxication was a significant problem in the railroad industry and that alcohol and drug abuse by railroad employees posed a serious threat to safety.

In applying the special needs test, the Court found that the warrant requirement is as unsuited to the employment situation as it is to the school environment at issue in the *New Jersey v. T.L.O.* case and that imposing a warrant requirement "would only serve to divert valuable agency resources from the Service's primary mission." *Von Raab*, 489 U.S. at 666-67. The Court further found that "a warrant would provide little or nothing in the way of additional protection of personal privacy," *id.* at 667, because the circumstances under which the testing would be conducted and the permissible limits of the search were narrowly defined and the employees were well aware of the policy and its procedures. The Court also found that the compelling governmental interests justified the urine testing even in the absence of probable cause or any individualized suspicions of drug use.

In evaluating the public interest component of the balancing test, the Court noted that the smuggling of illicit narcotics has created a national crisis, and that "[t]he Customs Service is our Nation's first line of defense against one of the greatest problems affecting the health and welfare of our population." *Id.* at 668. In light of such, the Court found that the Government has "a compelling interest in ensuring that front-line interdiction personnel are physically fit, and have unimpeachable integrity and judgment." *Id.* at 670. On the other side of the balancing scale, the Court found that the Customs employees "have a diminished expectation of privacy in respect to the intrusions occasioned by a urine test." *Id.* at 672.

The Court ultimately held that the warrantless and suspicionless testing policy was reasonable because the Government's "compelling interest in safeguarding our

borders and the public safety outweigh the privacy expectations of employees who seek to be promoted to positions that directly involve the interdiction of illegal drugs or that require the incumbent to carry a firearm." *Id.* at 677.

The Court revisited the application of the special needs doctrine to a drug testing policy in *Vernonia School District 47J v. Acton*, 515 U.S. 646 (1995). After observing a sharp increase in drug use among the student population and that athletes were the leaders of the drug culture, the school district adopted a Student Athlete Drug Policy that authorized random drug testing of students who participated in school athletic programs. The express purpose of the policy was "to prevent student athletes from using drugs, to protect their health and safety, and to provide drug users with assistance programs." *Id.* at 650.

Relying on its previous decision in *New Jersey v. T.L.O.*, the Court again found that special needs exist in the public school context which make the warrant and probable-cause requirement impracticable. *Id.* at 653. Turning then to the evaluation of the privacy interests, the Court found that the students' legitimate expectations of privacy were diminished because of the supervisory role of the school and the voluntary participation in extracurricular athletic activities. On the other side of the equation, the Court found that, with the clear evidence of an immediate crisis of great proportions,[10] deterring drug use by schoolchildren is an important governmental concern and it was "self-evident"

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[10] The District Court had found that "a large segment of the student body, particularly those involved in interscholastic athletics, was in a state of rebellion," and that "[d]isciplinary actions had reached epidemic proportions," and that "the rebellion was being fueled by alcohol and drug abuse as well as by the student's misperceptions about the drug culture." 796 F.Supp. 1354, 1357 (Ore. 1992).

the problem was effectively addressed by preventing drug use by student athletes. Taking all these factors into consideration, the Court concluded that the policy was reasonable.

The only case in which the Supreme Court has struck down a drug testing policy under a special needs analysis is *Chandler v. Miller*, 520 U.S. 305 (1997). At issue there was a Georgia statute which required that all candidates for certain state offices submit to a urinalysis for illegal drug use and test negative as a precondition to qualifying for a place on the ballot.

In addressing the espoused justification of the statute under the special needs doctrine, the Court reviewed and summarized its decisions in *Skinner*, *Von Raab*, and *Vernonia*: "Our precedents establish that the proffered special need for drug testing must be substantial – important enough to override the individual's acknowledged privacy interest, sufficiently vital to suppress the Fourth Amendment's normal requirement of individualized suspicion." *Id.* at 318. The Court found that the State of Georgia had failed to demonstrate any such special need. The key to the Court's decision appears to be a lack of evidence of a concrete danger that state officeholders in Georgia have drug problems; rather, Georgia merely presented a "symbolic" need to project its commitment to the fights against drugs.

While the Court has not addressed the exact same type of drug testing policy as presented in this case, it has clearly enunciated the guiding principles and parameters of the special needs doctrine. The Court of Appeals' application of that doctrine in sustaining the MUSC Medical Center policy on Management of Drug Abuse During Pregnancy is not in

conflict with the controlling precedent of this Court or any relevant decision of any other court of appeals. Accordingly, there is no compelling reason to grant the petition for a writ of certiorari.

III. The Special Needs Doctrine was Properly Applied to the MUSC Medical Center Maternity Policy.

A. There was a Well-Documented Special Need to Protect Pregnant Patients and their Children.

The first step in the special needs analysis is the determination of whether the search serves a special governmental need beyond normal law enforcement needs. Contrary to the Petitioners' assertions, the Court of Appeals faithfully applied this Court's precedent in holding that the MUSC Medical Center demonstrated a special need in preventing cocaine use by pregnant women.

The incontrovertible evidence is that both the obstetrical and neonatal medical staff had a clinically-based need for the information in order to manage the pregnancy and treat the newborns. It is also indisputable that medical communities in the City of Charleston, other areas of the State of South Carolina, and across this Nation were experiencing serious maternal and neonatal health problems as a result of the epidemic of prenatal drug abuse.

Since the "special need" was uniquely medical in nature, it was appropriately addressed on the frontline by medical personnel that could best identify the at-risk patients and most effectively implement a policy to prevent or treat prenatal drug abuse. Notably, the Petitioners' own expert, Dr. Chasnoff, urged the medical community to take

immediate action to stem the epidemic of prenatal cocaine abuse. [App. 26]

The words of Justice Powell in his concurrence in *New Jersey v. T.L.O.*, supra, illustrate how special relationships -- such as that between healthcare providers and their patients -- can establish a basis for recognizing special needs exceptions to the warrant/probable cause requirement:

> Law enforcement officers function as adversaries of criminal suspects. These officers have the responsibility to investigate criminal activity, to locate and arrest those who violate our laws, and to facilitate the charging and bringing of such persons to trial. Rarely does this type of adversarial relationship exist between school authorities and pupils. Instead, there is a commonality of interests between teachers and their pupils. The attitude of the typical teacher is one of personal responsibility for the student's welfare as well as for his education.

469 U.S. at 349. The Court in *Griffin v. Wisconsin* also found it pertinent that the primary role of a probation officer was not to investigate criminal activity, but to supervise his client with the goal of assuring that the probation served as a period of genuine rehabilitation.

By the same token, healthcare providers and patients do not stand in an adversarial relationship to each other. Instead, there is a commonality of interests between medical personnel and their patients. In maternity cases, the medical personnel and the patients share common interests in the health of both the mother and her child.

The medical staff does not conduct the drug screens for the purpose of investigating criminal activity. The purpose is to provide proper medical treatment to their patients. During pregnancy, so many factors effect the health of the mother, the course of the labor and delivery, and the health of the child, that the medical staff cannot adequately treat the pregnant patient or manage the pregnancy without such critical information as the patient's use of illegal drugs.

The opinion of the Court of Appeals cannot fairly be read, as the Petitioners assert, to establish any dangerous precedent that would permit law enforcement to engage in warrantless searches for just any and every health or safety reason. The Court of Appeals adhered to this Court's decisions in *Vernonia* and *Chandler*, in stressing that the governmental need must be "compelling" and that "the hazard giving rise to the alleged special need must be a concrete danger, not merely a hypothetical one." 186 F.3d at 477. The Court of Appeals correctly found that: "In light of the documented health hazards of maternal cocaine use and the resulting drain on public resources, MUSC officials unquestionably possessed a substantial interest in taking steps to reduce cocaine use by pregnant women." 189 F.3d at 478.

The Court has recognized in *Von Raab* that "drug abuse is one of the most serious problems confronting our society today." 489 U.S. at 674. However, the Court has drawn parameters for how far that problem will justify warrantless searches. In *Vernonia,* the special need for the school's random drug testing policy was justified by documented evidence of a sharp rise in drug use by student athletes and attendant injuries and disciplinary problems. On the other hand, in *Chandler v. Miller*, the State of Georgia could not produce any evidence of drug problems among state

officeholders to establish a special need sufficient to justify its mandatory drug testing for political candidates.

The Court of Appeals decision is not a radical departure from the parameters set by the Court. To the contrary, it squarely fits within those parameters as a clear case of a "special need" sufficient to sustain the MUSC Policy. In comparing the range of documentation and substantiation of the special needs, this case clearly aligns most closely with *Vernonia* where the school district presented solid evidence to document the existence and extent of the problem of drug abuse by its students and the harmful consequences to school discipline and the students' health. Unlike in *Chandler*, the special need to protect pregnant women and their children from prenatal cocaine abuse is not merely symbolic, but fully demonstrated by the evidence of an epidemic causing serious public health problems.

The Petitioners argue that any special needs search must be totally divorced from any law enforcement activity. However, this argument directly conflicts with the Court's repeated references to ""special needs' **beyond normal law enforcement**." *Griffin v. Wisconsin*, 483 U.S. at 873-74 (emphasis added.) The Court has never said that the "special need" must be to the exclusion of normal law enforcement goals. Nor do any of the special needs cases provide any foundation for the argument that involvement of the Solicitor or the Police Department in formation of the Policy somehow negated the well-documented "special need." Notably, in the case of *New Jersey v. T.L.O.* which came before the Court on appeal of the juvenile criminal case, the Court found no reason to invalidate the search because the fruits were ultimately turned over to the police.

This case does not present any evidence, direct or inferential, that the MUSC Medical Center's goal of protecting the health of its maternity patients and their children was merely a pretext to prosecute cocaine addicts. The record establishes that there was a very real medical epidemic and the Medical Center's only goal was to manage the pregnancies of its maternity patients and prevent maternal and infant injuries arising from prenatal cocaine abuse. The Medical Center had already attempted a protocol that proved ineffective and turned to other governmental agencies for help in formulating a Policy that would be more effective. It was the substance abuse counselors that supported the involvement of law enforcement to provide the coercive element necessary to make the Policy work. The purpose of the urine drug tests was not to prosecute the drug laws; rather, the threat of prosecution was but a tool in implementing a Policy that would prove to be effective in discouraging their patients from prenatal cocaine abuse.

B. MUSC's Interest in Protecting the Health of the Maternity Patients and their Children Outweighed the Minimal Intrusion on the Patients' Diminished Expectations of Privacy.

The second step in the special needs analysis is a balancing of the individual's privacy expectations against the government's interests. The balancing test of the special needs doctrine has been stated and applied in several variations.

In *Skinner*, the Court balanced the limited discretion exercised by the employers in determining which employees could be tested under the railroad policies, the "surpassing" interests in train safety, and the diminished expectation of privacy held by railway employees that participate in such a

heavy regulated industry. Similarly, in *Von Raab*, the Court balanced the government's compelling interest in preventing the promotion of drug users that might endanger the border security or public safety with the diminished expectation of privacy interests of the applicants for such security-sensitive positions. In *Vernonia*, the Court took into account the reduced expectation of privacy of school children, the relative insignificance of the intrusion, the important nature of the school's responsibilities and quasi-guardian relationship with its students, the documented immediacy of the drug problems; and the effectiveness of the policy.

The Court of Appeals properly evaluated the relevant factors. First, the court considered the extent of the documentation and the relative importance of the need in reducing cocaine use by pregnant women, finding ample evidence of the existence and magnitude of the epidemic of prenatal use of cocaine. 189 F.3d at 477-78. As to the effectiveness of the urine testing, the court found "little doubt that testing the urine of maternity patients when certain indicia of possible cocaine use were present was an effective way to identify and treat maternal cocaine use...." *Id.* at 478. Finally, the court found the degree of intrusion minimal in light of the fact that (1) the collection and testing of urine was a normal, routine and expected part of the medical treatment to which the Petitioners had consented[11] and (2) the urine tests were performed based on a non-discretionary application of the criteria delineated in the

[11] A urine test taken by a physician in a hospital environment pursuant to accepted medical practices is generally considered reasonable even without a warrant. *Schmerber v. California*, 384 U.S. 757, 771 (1966).

Policy.[12] In balancing these factors, the Court of Appeals correctly found that the searches were reasonable.

All of the special needs cases involved warrantless searches, but they also involved a range of levels of suspicion. The policies in *Von Raab, Vernonia,* and *Chandler* all called for drug testing without any level of individualized suspicion. In contrast, the policy is *Skinner* was based on specific factors that provided the basis for some level of individualized suspicion. Likewise, in *New Jersey v. T.L.O.*, the search was predicated on individualized suspicion.

The searches in this case were not suspicionless. The criteria for performing the test was medically-based, and provided amble suspicion to believe that the patients had been using cocaine.

IV. The Decision of the Court of Appeals is Not in Conflict with the Decisions of Other Circuits.

The decision of the Court of Appeals for the Fourth Circuit is not, as the Petitioners claim, in conflict with any decisions from other circuits. To the contrary, the Court of Appeals' decision is completely consistent with those of its sister circuits.

A number of the circuit court decisions closely tract this Court's special needs decisions, both factually and analytically, in upholding random and mandatory drug

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[12] The Petitioners argue that the Fourth Circuit improperly applied the balancing test enunciated in *Michigan Dept. of State Police v. Sitz*, 496 U.S. 444 (1990). However, the Court itself relied upon *Sitz* in its opinion in *Vernonia School District v. Acton*, 515 U.S. at 654.

testing policies in a number of industries ranging from schools to nuclear power plants to horse racing.[13] Those few decisions where the circuits have struck down drug testing policies are also consistent with this Court's precedent and distinguishable from the case here.

For example, in *United Teachers of New Orleans v. Orleans Parish School Board*, 142 F.3d 853 (5th Cir. 1998), the court struck down a school policy that required any employee injured in the course of employment to submit to drug testing because there was no documented problem of drug use by teachers or their teachers' aids or clerical workers. In *19 Solid Waste Dep't Mechanics v. City of Albuquerque*, 156 F.3d 1068 (10th Cir. 1998), the court found that a city program for drug testing trash truck mechanics

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[13] *Aubrey v. School Bd. of Lafayette Parish*, 148 F.3d 559 (5th Cir. 1998) (random drug testing of safety sensitive employees); *Todd v. Rush County Schools*, 133 F.3d 984 (7th Cir.), *cert. denied*, 119 S.Ct. 68, 142 L.Ed.2d 53 (1998) (random drug testing of students as condition of participation in any extracurricular activities); *Stigile v. Clinton*, 110 F.3d 801 (D.C. Cir. 1997), *cert. denied*, 522 U.S. 1147 (1998) (mandatory testing of all employees in certain sensitive positions); *International Bhd. of Elec. Workers, Local 1245 v. U.S. Nuclear Regulatory Comm'n*, 966 F.2d 521 (9th Cir. 1992) (random drug testing of employees of nuclear power plant); *Dimeo v. Griffin*, 943 F.2d 679 (7th Cir. 1991) (random drug testing of horse race participants); *Willner v. Thornburgh*, 928 F.2d 1185 (D.C. Cir.), *cert. denied*, 502 U.S. 1020 (1991) (mandatory drug testing of all applicants for positions as attorneys at Department of Justice); *Penny v. Kennedy*, 915 F.2d 1065 (6th Cir. 1990) (mandatory testing of firefighters and police officers); *Bluestein v. Skinner*, 908 F.2d 451 (9th Cir. 1990), *cert. denied*, 498 U.S. 1083 (1991) (random drug testing of airline employees); *Transport Workers' Union of Philadelphia, Local 234 v. Southeastern Pennsylvania Transp. Auth.*, 884 F.2d 709 (3rd Cir. 1989) (random drug testing of railroad employees in safety-sensitive positions); *Schaill v. Tippecanoe County School Corp.*, 864 F.2d 1309 (7th Cir. 1989) (random drug testing of athletes and cheerleaders).

was not well-designed to detect drug use and lacked any deterrent effect.

The decision of the Court of Appeals in this case in no way conflicts with these decisions. Unlike in *Chandler v. Miller* or *United Teachers of New Orleans*, the problem of prenatal cocaine use, the consequent harm, and the medical necessity for the testing were well documented. And, in contrast to the *City of Albuquerque* program, the MUSC Medical Center the program was well designed to identify pregnant patients who were using cocaine and proved effective in deterring prenatal cocaine use and preventing the consequent harm to the health of the mothers and children alike.

The potential danger to students from drug use by a school custodian, as in *Aubrey v. School Board of Lafayette Parish*, supra, is much more attenuated that the immediate and direct risk to the unborn children of mothers who use cocaine during the pregnancy. If a school board can require random testing of a school custodian in order to protect the students, surely a public hospital can perform suspicion-based drug testing of pregnant mothers to protect the health of the unborn children and the mothers themselves.

The appropriate application of the special needs doctrine in this case perhaps is best seen and understood by comparing two decisions arising out of child abuse and neglect investigations. *Franz v. Lytle*, 997 F.2d 784 (10th Cir. 1993); and *Wildauer v. Frederick County*, 993 F.2d 369 (4th Cir. 1993).

In *Franz*, a police officer investigating a case of possible sexual abuse conducted a warrantless inspection of the child's vaginal area and forcibly removed the child for

medical examination. The police officer argued that the "societal imperative to protect children" justified his actions under the special needs doctrine. While expressing a "deep concern for the safety and well-being of young children," the court rejected the special needs argument because the primary focus of the police officer's investigation was the potential criminal culpability of the parents:

> What the district court perceived, and what cannot be overlooked, is that defendant's focus was not so much on the child as it was on the potential criminal culpability of her parents. That focus is the hallmark of a criminal investigation. In contrast, a social worker's principal focus is the welfare of the child. While a criminal prosecution may emanate from the social worker's activity, that prospect is not part of the social worker's cachet.

997 F.2d at 791; *see also Darryl H. v. Coler*, 801 F.2d 893 (7th Cir. 1986) (possibility of criminal prosecution was contingency of only secondary importance to social worker).

In contrast, the Court of Appeals for the Fourth Circuit upheld a medical examination by a public health nurse that accompanied a social worker in the course of a child neglect investigation, finding that the state's interest in examining the neglected children outweighed any attenuated privacy interest.

These two cases illustrate two important distinguishing factors: (1) the official role of the person or entity conducting the search; and (2) the primary focus of the search. In this case, the searches in this case where conducted by medical personnel, not law enforcement officers, and the primary focus of the search was to manage

the pregnancy and protect the health of both the mother and the infant. Similarly, a social worker's principal focus is the welfare of the child. While a criminal prosecution may emanate from the social worker's activity, that prospect is not part of the social worker's cachet. Likewise, here, the principal focus of the MUSC medical staff was the welfare of the pregnant patient and her child, and while a criminal prosecution might emanate from the activity, that prospect is not part of the medical staff's "cachet."

V. There are Alternate Independent Grounds to Sustain the Finding of No Fourth Amendment Violation.

The petition for a writ of certiorari should be denied because there is no conflict with the established precedent of this Court or any decision of another circuit regarding the application of the special needs doctrine to the facts of this case. In addition, the petition should be denied because judgment for Defendants is otherwise sustainable under the alternate independent grounds that the Petitioner consented to the drug tests or that the MUSC medical staff were not state actors subject to the strictures of the Fourth Amendment.

A. The Petitioners consented to the drug tests.

"[O]ne of the specifically established exceptions to the requirements of both a warrant and probable cause is a search that is conducted pursuant to consent." *Schneckloth v. Bustamonte*, 412 U.S. 218, 219 (1973). Each of the Petitioners signed one of the consent to treatment forms. In addition, evidence was presented to the jury that all patients were given a letter at the time of their initial visit which explained the urine drug testing policy and clearly put them

on notice that law enforcement would be contacted if they did not get treatment. [PA 56-57] Also, many of the Petitioners admitted seeing or hearing the public service announcements about the Policy. Several of the Petitioners admitted that they were aware of the Policy at the time they sought treatment at MUSC and provided urine specimens for testing. The jury's factual finding that the Petitioners consented to the drug testing is fully supportable by the evidence adduced during the six-week trial and stands as an independent ground for sustaining the judgment that there was no Fourth Amendment violation.

B. The MUSC Medical Center staff were not state actors subject to the strictures of the Fourth Amendment.

The MUSC Medical Center and its medical staff have maintained throughout this litigation that they are not state actors subject to the Fourth Amendment. No case has extended the application of the Fourth Amendment to medical personnel in a public hospital based solely on their status as government employees. However, to the contrary, the Court of Appeals for the Ninth Circuit has ruled that not all healthcare providers in public hospitals are acting as agents of the police subject to the Fourth Amendment in obtaining and testing bodily fluids in every case. *United States v. Attson*, 900 F.2d 1427, 1434 (9th Cir.), *cert. denied*, 498 U.S. 961 (1990).

The Fourth Amendment only applies if law enforcement instigated, encouraged or participated in the "search" and the healthcare provider engaged in the search with the intent of assisting the police in their investigative efforts. If there is a "dual purpose" – both medical and investigative – the search retains its private character, and if the search is "private" at

the inception, subsequent voluntary disclosure of the police does not implicate the Fourth Amendment.

Here, the medical purpose is undeniably a legitimate, independent motivation for performing the urine drug screens. Thus, at worst, there was arguably a "dual purpose." In this situation, the Fourth Amendment simply does not apply to the conduct of the MUSC Medical Center and its staff.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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TABLE OF CONTENTS
to Respondents' Appendix

Page

Testimony of Lori Griffin 1

Testimony of Laverne Singleton 1

Testimony of Ellen Knight 1

Testimony of Sandra Powell 2

Testimony of Crystal Ferguson 2

Testimony of Paula Hale 3

Testimony of Theresa Joseph 3

Testimony of David Annibale, M.D. 3

Testimony of Stanley C. Baker, M.D. 4

Testimony of Judith A. Bays, M.D. 4

Testimony of Shirley J. Beckett 11

Testimony of Shirley Brown, R.N. 11

Testimony of Ira J. Chasnoff 13

Testimony of Charles Condon 29

Testimony of James B. Edwards 32

Testimony of Joseph C. Good 32

Testimony of Edgar O. Horger, M.D. 33

Testimony of Herbert D. Kleber, M.D. 39

Testimony of Roger Newman, M.D. 45

Testimony of William B. Pittard, M.D. 58

Testimony of Thomas Rowland, M.D. 59

Testimony of Sarah E. Schuh 60

Joint Exhibit # 12/Consent Form 60

Joint Exhibit #13/Consent Form 64

Plaintiffs' Exhibit # 63/ Letter of Dr. Newman 66

Defendants' Exhibit # 133/
1991 S.C. Prevalence Study of Drug Use 72

Testimony of David Schwacke 79

Testimony of Lori Griffin
[Tr. 46, lines 2-7]

Q. NOW, SOME GOOD CAME FROM ALL OF THIS, DIDN'T IT? YOU GOT OFF OF COCAINE?

A. I RELAPSED.

Q. AND HAVE YOU RELAPSED SINCE WE TOOK YOUR DEPOSITION? YOU'RE OFF OF IT NOW?

A. OH, I'M OFF OF IT NOW, YES.

Testimony of Laverne Singleton
[Tr. 118, lines 18-24]

Q. (BY MR. HOOD, CONTINUING) YOU THEN WERE ASKED WHAT I ASKED YOU A MINUTE AGO ABOUT CHARLESTON COUNTY SUBSTANCE ABUSE WERE YOU HAD COUNSELING. EARLIER TODAY I ASKED YOU IF IT WAS HELPFUL AND YOU SAID NO. ON LINE 15 YOU WERE ASKED, "DID YOU FIND THEIR SESSIONS HELFUL?"

AND YOUR ANSWER?

A. "YES."

Testimony of Ellen Knight
[Tr. 147, lines 2-8]

Q. (BY MS. SHOWERS, CONTINUING) MS. KNIGHT, YOU GOT SUBSTANCE ABUSE TREATMENT AT CHARLESTON COUNTY SUBSTANCE ABUSE?

A. YES.

Q. AND YOU SUCCESSFULLY COMPLETED THAT TREATMENT AND YOU'RE OFF DRUGS; IS THAT RIGHT?

A. YES.

Testimony of Sandra Powell
[Tr. 178, lines 3-7]

Q. AFTER USING COCAINE FOR A SIGNIFICANT PERIOD OF TIME YOU GOT INTO SUBSTANCE ABUSE AND SUCCESSFULLY COMPLETED SUBSTANCES ABUSE. HAVE YOU EVER USED COCAINE SINCE YOUR ARREST, MS. POWELL?

A. NO.

Testimony of Crystal Ferguson
[Tr. 202, lines 7-15]

Q. AND WHEN I TOOK YOUR DEPOSITION, DO YOU RECALL TELLING ME THAT THE SUBSTANCE ABUSE TREATMENT THAT YOU GOT AT CHARLESTON COUNTY SUBSTANCE ABUSE COMMISSION WAS HELFUL AND EFFECTIVE?

A. YES, SIR. YES, MA'AM.

Q. AND, MS. FERGUSON, YOU'RE CURRENTLY PREGNANT NOW; ISN'T THAT TRUE?

A. YES, I AM.

Q. ARE YOU USING COCAINE DURING THIS PREGNANCY?

A. NO, MA'AM.

Testimony of Paula Hale
[Tr. 115, lines 10-11]

Q. AFTER YOU GOT OUT OF JAIL DID YOU USE ANY DRUGS?

A. NO.

Testimony of Theresa Joseph
[Tr. 20, lines 9 –12]

Q. AND YOULD YOU SAY CHARLESTON COUNTY SUBSTANCE ABUSE WAS A FACTOR IN YOUR GETTING SUCCESSFUL TREATMENT?

A. IT WAS SOME HELP, TOO, ALONG WITH ME AND MY FAMILY.

Testimony of David Annibale, M.D.
[Tr. 237, lines 18-24]

Q. (BY MS. SHOWERS, CONTINUING) SURE. COULD YOU EXPLAIN TO THE JURY THE MEDICAL NECESSITY OF TESTING OR EVEN KNOWING THAT A NEWBORN HAS TESTED POSITIVE FOR DRUGS?

A. THERE ARE CERTAIN MEDICAL CONDITIONS THAT ONE WOULD SEE IN NEWBORN -- IN A NEWER BORN INFANT THAT COULD BE THE RESULTS OF EXPOSURE TO DRUGS OR WITHDRAWAL FROM EXPOSURE TO DRUGS THAT COULD PRESENT IN THE FIRST SEVERAL DAYS OF LIFE.

Testimony of Stanley C. Baker, M.D.
[Tr. 608, lines 22-25]

Q. AS YOU UNDERSTAND IT, WHAT WAS THE GOAL THAT WAS HOPED TO OBTAINED BY THIS POLICY?

A. TO PROTECT THE MINDS OF THOSE UNBORN CHILDREN AND TO HOPEFULLY HELP THE MOTHERS KICK THE HABIT OF COCAINE.

Testimony of Judith A. Bays, M.D.
[Tr. 18, line 6 – tr. 24, line 12]

A. THEY CAN BE--THEY CAN BE SMALL IN LENGTH AND SMALL IN WEIGHT, TOO, BUT THERE'S OFTEN A DISPROPORTIONATE SMALL HEAD SIZE, MEANING ALTHOUGH THE BABY ITSELF IS SMALL, THE HEAD IS SMALLER THAN IT SHOULD BE EVEN FOR A SMALL BABY. AND THAT REFLECTS DAMAGE TO THE BRAIN OR POOR BRAIN GROWTH. AND THAT'S THE MOST CONCERNING THING WE SEE.

OTHER THINGS THAT WE SOMETIMES SEE ARE RELATED TO WHAT COCAINE DOES IN TERMS OF CUTTING OFF THE BLOOD SUPPLY. WE CALL IS VASOCONSTRICTION. VASO MEANS BLOOD VESSEL AND CONSTRICTION MEANS IT SHUTS IT DOWN. AND THAT'S THE WAY COCAINE AFFECTS PEOPLE, ADULTS AND BABIES, IS IT--IT CLOSES DOWN THESE SMALL BLOOD VESSELS AND THEN IT SHUTS OFF THE OXYGEN AND--OXYGEN SUPPLY, THE BLOOD SUPPLY, THE FOOD SUPPLY TO WHATEVER WAS BEYOND THE SHUTDOWN BLOOD VESSEL.

SO IN AN ADULT YOU WOULD CALL THAT STROKE. IF YOU HAD THAN HAPPEN IN YOUR BRAIN, THAT WOULD BE A STROKE. SO PART OF YOUR BRAIN COULD BE DAMAGED OR ACTUALLY DIE. IF IT HAPPENS IN YOUR HEART, IT'S CALLED A HEART ATTACK BECAUSE A PART OF THE MUSCLE IN YOUR HEART DIES. SO WE HAVE SEEN IT IN INFANTS WHERE IT HAPPENS IN THEIR BRAIN. AND THE BRAIN--BRAIN GROWTH IS AFFECTED OR PARTICULAR PARTS OF THE BRAIN ARE KNOCKED OUT.

IF IT--THERE ARE CASE REPORT--I HAVEN'T SEEN THIS PERSONALLY, BUT THERE ARE CASE REPORTS OF SEVERAL INFANTS WITH HEART ATTACKS RELATED TO MATERNAL USE OF COCAINE. THEN IF IT HAPPENS TO THE GUT, PORTIONS OF THE GUT CAN DIE BEFORE BIRTH. IF IT HAPPENS TO THE DEVELOPING FINGERS AND TOES OF THE FETUS, THEN THE FINGERS AND TOES WON'T DEVELOP BECAUSE THE BLOOD SUPPLY IS CUT OFF TO THEM. AND THAT'S WHY WE THINK

WE GET--WE SEE THESE--WHAT WE CALL LIMB REDUCTION DEFECTS WHERE THEY'RE MISSING FINGERS, TOES OR ACTUALLY PART OF THE ARM OR LEG. IF IT HAPPENS TO THE KIDNEYS, YOU CAN BE--YOU CAN HAVE KIDNEY DAMAGE OR MISSING KIDNEY. IF IT HAPPENS TO THE GENITOURINARY SYSTEM, THEIR REPRODUCTIVE SYSTEM, THEN PART OF THAT CAN BE DAMAGED, TOO.

BUT THOSE ARE THE MOST CONCERNING EFFECTS WE SEEN WHEN THE--THE BLOOD AND OXYGEN SUPPLY IS CUT OFF TO A PART OF THE DEVELOPING BABY. THE MOST CONCERNING, OF COURSE, WOULD BE THE HEART OR THE BRAIN. LATER ON, WE SEE SOME BEHAVIORAL AND NEUROLOGIC EFFECTS WHICH ARE VERY CONCERNING TOO.

Q. AND ALL OF THESE EFFECTS THAT YOU HAVE DESCRIBED DR. BAYS, IN YOUR OPINION, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY MOST PROBABLY, ARE THEY A RESULT OF COCAINE EXPOSURE IN UTERO?

A. YES.

MS. SMITH: OBJECTION, IRRELEVANT, PREJUDICIAL. LACK OF FOUNDATION.

Q. WHAT OTHER RISKS DO CHILDREN WHO ARE PRENATALLY EXPOSED TO COCAINE FACE AS THEY GROW AND DEVELOP, DOCTOR?

A. WELL, THEIR—THEY HAVE PARTICULAR LEARNING DISABILITIES. SOME OF THEM, NOT

ALL OF THEM. THERE'S A WHOLE SPECTRUM. SOME BABIES MAY APPEAR TO BE NOT AFFECTED AT ALL AND THEN SOME BABIES ARE MORE MILDLY AFFECTED, MORE MODERATELY AFFECTED AND THEN SOME BABIES SEVERELY AFFECTED. SO WE SEE THE WHOLE SPECTRUM. SO I'M GOING TO GIVE YOU WHAT WE HAVE SEEN ON THE MORE WORRISOME END OF THINGS.

WE SEE BABIES THAT ARE--AS THEY GROW ARE HYPERACTIVE AND HAVE ATTENTION DEFICIT DISORDER. THEY HAVE DIFFICULTY FOCUSING ON A TASK AND PAYING ATTENTION TO THE TASK. THEY HAVE DIFFICULTY WITH ORGANIZED PLAY, MEANING, LET'S SAY YOU'RE GOING TO PLAY HOUSE. THEY DON'T UNDERSTAND HOW TO PLAY HOUSE, HOW TO HAVE THE, YOU KNOW, THE DADDY COME HOME AND MOMMY FIX DINNER AND SO ON. THEY CAN'T SEQUENCE. SEQUENCING IS A PROBLEM, PUTTING THINGS IN ORDER. SO THIS IS FIRST, THIS IS SECOND, THIS IS THIRD. SO SOCIAL PLAY, INTERACTIVE PLAY.

EARLY ON, ONE OF THE TWO THINGS THAT ARE SEEN IN--AND CAN CONTINUE LATER IN LIFE ARE DIFFICULTIES WITH-AND THIS IS PART OF FOCUSING-DIFFICULTY WITH FOCUSING ON THE GAZE. IT'S CALLED GAZE AVERSION WHERE BABIES WON'T LOOK AND HOLD A LOOK, A GLANCE. AND THIS CONCERNS US BECAUSE THIS IS PART OF THE BONDING PROCESS BETWEEN THE MOTHER AND THE INFANT IS FOR THE MOTHER TO LOOK IN THE BABY'S FACE AND THE BABY TO LOOK BACK. AND SOME OF THESE INFANTS DON'T WANT--DON'T SEEM TO WANT TO LOOK AT A

FACE, AND WILL LOOK AWAY, WHEREAS NORMAL BABIES WILL PREFER TO LOOK AT A FACE. AND THAT'S PART OF THE NORMAL BONDING PROCESS. SO WE'RE CONCERNED IT MAKES BABIES MORE DIFFICULT TO REAR WHEN THEY'RE NOT LOOK AND SMILING AT THE ADULT CARETAKER AND MAKES THEM AT HIGHER RISK OF ABUSE.

I THINK THE MOST CONSISTENT PATTERN THAT PEOPLE ARE SEEING IS EFFECT ON LANGUAGE. LANGUAGE--AND THIS--THIS IS BOTH LANGUAGE PROCESSING SO THIS IS THE INPUT OF LANGUAGE, THIS IS, A CHILD UNDERSTANDING WHAT YOU'RE ASKING THEM TO DO. SOMETIMES DON'T SEEM TO BE ABLE TO PROCESS THE VERBAL INFORMATION COMING IN WELL.

THEN THERE'S ALSO A PRODUCTION DEFECT THAT SOME OF THEM DON'T SEEM TO BE ABLE TO PRODUCE LANGUAGE WELL. AND PART OF IT IS A MOTOR DIFFICULTY WITH MOVEMENTS OF THE MOUTH AND THE TONGUE, BUT PART OF IT IS WHAT WE CALL A CENTRAL PROCESSING DEFECT, LIKE THE CENTRAL COMPUTER OF THE BRAIN IS NOT PRODUCING--PROCESSING AND PRODUCING LANGUAGE NORMALLY. SO WHEN--IN ITS MOST SEVERE FORM, WE SEE WHAT WE CALLED PARROTING WHERE A CHILD SEEMS TO SPEAK FLUENTLY, BUT THEN IF YOU EXAMINE THEM A LITTLE MORE CAREFULLY AND QUESTION THEM A LITTLE MORE CAREFULLY, IT TURNS OUT THEY'RE JUST RECITING BACK WHAT THEY'VE HEARD.

I'LL GIVE YOU AN EXAMPLE. I SAW A CHILD, A COCAINE AFFECTED CHILD IN THE

OUTPATIENT CLINIC A FEW YEARS AGO AND SHE WAS ABOUT THREE. AND WHEN I WALKED IN THE ROOM I SAID, "HI, HOW ARE YOU?" AND SHE SAID, "HI, HOW ARE YOU?" AND I SAID, "WHAT'S YOUR NAME?" AND SHE SAID "WHAT'S YOUR NAME?" AND UP TO THERE--UP TO THAT POINT, I THOUGHT SHE WAS DOING PRETTY WELL FOR A THREE YEAR OLD BECAUSE SHE COULD PRODUCE FULL SENTENCES. BUT THEN IT TURNED OUT SHE COULDN'T SPEAK SPONTANEOUSLY. SHE COULD ONLY PARROT BACK OR RECITE BACK WHAT SHE HAD HEARD FROM ME. SO SHE HAD NO GOOD SPONTANEOUS SPEECH OF HER OWN WHICH IS VERY, VERY WORRISOME PROBLEM.

AND SO IN TALKING TO PEOPLE AROUND THE COUNTRY WHO ARE WORKING WITH COCAINE AFFECTED INFANTS AND FOLLOWING THEM LONG TERM, LANGUAGE IS ONE OF THE CONSISTENT THINGS THAT WE'RE SEEING. AGAIN, NOT IN EVERY CHILD, BUT IN MANY CHILDREN.

Q. WHAT ABOUT IN THE HOME, DOCTOR, HAVE YOU LOOKED AT THE RISK OF CHILD ABUSE AND NEGLECT TO CHILDREN THAT HAVE BEEN EXPOSED TO COCAINE IN UTERO?

MS. SMITH: AGAIN, I OBJECT TO HIS LINE OF QUESTIONING AS IRRELEVANT AND PREJUDICIAL. IT'S SIMPLY NOT AT ISSUE IN THIS CASE.

Q. GO AHEAD, DOCTOR.

A. I LOOKED AT THIS IS A STUDY THAT WE DID

AND THAT WE'RE STILL DOING AND THEN THERE IS SOME LITERATURE THAT EXISTS FROM OTHER PARTS OF THE COUNTRY ON THIS ISSUE. THE RISK OF ABUSE AND NEGLECT TO CHILDREN WHO ARE BEING RAISED IN SUBSTANCE ABUSING FAMILIES IS DEFINITELY HIGHER, SOMEWHERE BETWEEN TWO AND FIVE TIMES HIGHER DEPENDING ON THE STUDY. ABOUT THREE TIMES HIGHER.

Q. WHAT ABOUT THE PARENTING BY THESE CHILDREN IN TERMS OF FOLLOW-UP MEDICALLY, IS THERE ANY CORRELATION THERE?

A. YES.

MS. SMITH: SAME OBJECTION. ALSO OBJECT AS TO VAGUE.

A. YES.

Q. GO AHEAD, DOCTOR.

A. THERE--THERE IS SOME INFORMATION IN THE MEDICAL LITERATURE INDICATING THAT MEDICAL FOLLOW UP IS POORER IN TERMS OF NUMBERS OF IMMUNIZATIONS OR MISSED MEDICAL APPOINTMENTS.

Q. DOCTOR, CAN A SINGLE DOSE OF COCAINE BY HARMFUL TO A DEVELOPING FETUS?

A. YES.

Q. CAN IT ACTUALLY KILL EITHER THE BABY OR THE MOTHER OR BOTH?

A. YES.

[Tr.25, lines 9-12]

A. THE APPROACH IS SIMILAR TO ONE THAT MANY HOSPITALS AROUND THE COUNTY, INCLUDING OURS, HAVE USED. SOME—THERE ARE SPECIFIC DIFFERENCES, BUT IT'S BASICALLY VERY SIMILAR.

Testimony of Shirley J. Beckett
[Tr. 270, lines 11-15]

Q. (BY MS. COMPANION, CONTINUING) I'LL REPEAT MY QUESTION. SOME OF THE INDIVIDUALS REFERRED FROM THE MEDICAL UNIVERSITY DID SUCCESSFULLY COMPLETE SUBSTANCE ABUSE TREATMENT, DIDN'T THEY?

A. YES, THEY DID.

Testimony of Shirley Brown, R.N.
[Tr. 30, lines 16-22]

Q. OKAY, NOW, MS. BROWN, LET'S GO BACK TO THAT INTRAUTERINE. FETAL DEATH. AND IN CONJUNCTION WITH THAT THE INTENT OF THE POLICY , THE REASON WE DECIDED ON THIS POLICY, AT THE FIRST MEETING, WAS BECAUSE OF OUR CONCERN AND AS MR. HOOD SAID IN HIS OPENING, FOR THE HEALTH AND SAFETY AND

CARE OF THESE FETUSES AND SOON TO BE CHILDREN; FAIR?

A. THAT IS CORRECT.

[Tr. 160, line 25 – tr. 161, line 20]

Q. WITH RESPECT TO THE LIST OF THE IDENTIFYING CHARACTERISTICS FOR URINE SCREENS, WOULD YOU TELL ME WHY NO PRENATAL CARE WAS IMPORTANT AS AN IDENTIFYING CHARACTER?

A. BECAUSE OF THE LITERATURE WHICH SUGGESTS THAT WOMEN WHO DID NOT SEEK PRENATAL CARE WERE AT RISK FOR COCAINE ABUSE.

Q. WHAT LITERATURE WAS THAT THAT SUGGESTED PEOPLE WHO DIDN'T GET PRENATAL CARE USED COCAINE?

A. SOME OF IT WAS PUBLISHED BY DOCTOR IRA CHASNOFF.

Q. AND IS THAT THE LITERATURE THAT YOU RELIED UPON, THE CHASNOFF LITERATURE TO MAKE THAT ONE OF THE CRITERIAS?

A. I DO NOT RECALL ALL OF THE LITERATURE THAT WAS REVIEWED AT THAT POINT IN TIME.

Q. LATE PRENATAL CARE AFTER 24 WEEKS, CHASNOFF AGAIN?

A. I DON'T RECALL THE REFERENCES ON THAT.

Q. INCOMPLETE PRENATAL CARE. CHASNOFF AGAIN?

A. I DO NOT RECALL THE REFERENCE.

Q. ABRUPTIO PLACENTAE?

A. THAT WAS OUT OF SOME OF DR. CHASNOFF'S WORK.

Q. INTRAUTERINE FETAL DEATH, CHASNOFF? THE BABY DIED IN UTERO WAS CAUSED BY COCAINE?

A. I CAN'T REMEMBER WHOSE ARTICLE THAT WAS FROM.

Testimony of Ira J. Chasnoff
[Tr. 13, lines 20-23]

Q. IS THERE ANYTHING UNIQUELY HARMFUL ABOUT COCAINE IN TERMS OF PRENATAL EXPOSURE?

A. COCAINE IS UNIQUE IN THAT IT HAS A VERY DIRECT EFFECT AND SUDDEN EFFECT.

[Tr.32, line 12 – tr. 43, line 22]

Q. YOU HAVE SPENT THE LAST 20 YEARS OF YOUR CAREER DOCUMENTING THE ADVERSE

EFFECTS OF COCAINE USE ON PREGNANCY AND THE EFFECTS IN UTERO? TRUE?

A. TRUE.

Q. YOU BEGAN DOCUMENTING THE ADVERSE EFFECTS OF COCAINE ON FETUSES IN UTERO IN THE LATE 1970'S, TRUE?

A. NO, ACTUALLY IT STARTED IN THE EARLY '80'S AND PUBLISHED IN '85.

Q. AND YOU AGREE WITH ME THAT COCAINE USE DURING PREGNANCY SHOULD BE DISCOURAGED?

A. I AGREE WITH THAT, YES.

Q. AND THAT DRUGS TAKEN DURING PREGNANCY WILL CROSS THE PLACENTA BARRIER AND REACH THE BABY?

A. YES, THESE SUBSTANCES INCLUDING TOBACCO AND ALCOHOL.

Q. MY QUESTION WAS JUST COCAINE.

A. NO, YOU SAID DRUGS.

Q. COCAINE WILL CROSS THE BARRIER ALSO.

WOULD YOU EXPLAIN TO THE JURY WHAT YOU MEAN BY THAT THE PLACENTAL BARRIER?

A. YES, THE PLACENTA IS THE TISSUE THAT BASICALLY TRANSFERS BLOOD AND NUTRIENTS FROM THE MOTHER TO THE BABY THOUGH ITS VASCULAR SYSTEM AND THE UMBILICAL CORD TO THE BABY. AND IT, RATHER THAT ACTING AS ANY KIND OF BARRIER OR PROTECTING THE BABY, RATHER IT'S MORE LIKE A SIEVE. THAT ANY--ANYTHING THAT THE MOTHER INGESTS WILL CROSS FROM THE MOTHER TO THE BABIES.

Q. IN YOUR EARLY ARTICLES ON COCAINE USE DURING PREGNANCY, YOU NOTED THAT THERE WAS AN INCREASED RATE OF PLACENTAL ABRUPTIONS ASSOCIATED WITH COCAINE USE DURING PREGNANCY?

A. YES, THAT CAN BE ASSOCIATED WITH ABRUPTIONS.

Q. CAN YOU EXPLAIN TO THE JURY WHAT ABRUPTION IS?

A. WHEN A WOMEN GOES INTO LABOR THE UTERUS STARTS CONTRACTING AND THE BABY WILL DELIVER. AND AFTER THAT THE PLACENTA WILL THEN SEPARATE FROM THE WALL OF THE UTERUS AND BE DELIVERED. AND THAT'S AFTERBIRTH. IN ABRUPTION THERE ARE CERTAIN CONDITIONS LIKE THE WOMEN HAS HYPERTENSION, HIGH BLOOD PRESSURE, IT CAN LEAD TO ABRUPTION. IF A WOMEN SMOKES TOBACCO OR USES COCAINE OR AMPHETAMINES, THOSE ARE ALL RISK FACTORS FOR INCREASING THE RISK OF ABRUPTION.

Q. AND THE PLACENTA SEPARATES AND THE WOMEN BLEEDS?

A. THE PLACENTA SEPARATES THE WOMEN CAN BLEED AND THE BABY CAN LOSE OXYGEN

Q. AND DIE?

A. THAT'S A POSSIBILITY.

Q. AND IN 1989, YOU DOCUMENT THE HARMS OF COCAINE USE ON THE FETUS TO INCLUDE CONGENITAL ANOMALIES?

A. YES, THERE IS AN INCREASED RATE OF CONGENITAL ANOMALIES.

Q. CAN YOU EXPLAIN TO THE JURY WHAT A CONGENITAL ANOMALY IS?

A. WELL CONGENITAL ANOMALY IS WHEN THE BABY IS BORN WITH SOME TYPE OF MALFORMATION IS THE WAY TO THINK OF IT. CAN RESULT AGAIN FROM A VARIETY OF FACTORS INCLUDING ALCOHOL, THAT'S PROBABLY THE MOST COMMON DRUG THAT CAUSES THESE KINDS OF ANOMALIES. COCAINE, ALSO.

Q. COCAINE USE ON A FETUS HAS ALSO BEEN DOCUMENTED TO CAUSE WITHDRAWAL?

A. NO. COCAINE HAS NEVER BEEN SHOWN TO HAVE AN EFFECT OF WITHDRAWAL. THE ONLY DRUG HAS BEEN HEROIN.

Q. I SHOULD HAVE CHARACTERIZE THAT, DOCTOR. IN 1989 YOU DOCUMENTED THAT COCAINE USE DURING PREGNANCY COULD CAUSE WITHDRAWAL?

A. NO, WE NEVER SAID THAT IT CAUSED WITHDRAWAL. IT WAS--WE SHOWED THAT IT CAUSED NEURO--NEUROLOGICAL CHANGES IN THE BABY, BUT A CLEAR SYNDROME OF WITHDRAWAL FROM COCAINE HAS NEVER BEEN CLEARLY DOCUMENTED.

Q. PAGE 19, LINE 6.

MS. DUNN: WHICH DEPOSITION?

Q. (BY MS. SHOWERS, CONTINUING) DO YOU REMEMBER WHEN I TOOK YOUR DEPOSITION, DR. CHASNOFF?

A. YES. OH, YES I DO.

Q. WE WERE IN THE AIRPORT IN CHICAGO, AS I RECALL, CORRECT?

A. YES

Q. OKAY. AND AT LINE 6 ON PAGE 19, I SAID:

AND THE DOCUMENTED EFFECTS OF COCAINE USE ON FETUS IN 1989 INCLUDED CONGENITAL ANOMALIES?

AND YOUR ANSWER WAS: YES

AND THEN AT LINE 6: FETAL DEPENDENCE ON DRUG RESULTING IN WITHDRAWAL, IRRITABILITY, RELENTLESSNESS, POOR FEEDING, CRYING, IMPAIRED NEUROBEHAVIORAL ABILITIES TREMULOUSNESS, INCREASE IN THE COMPLICATIONS IN LABOR AND DELIVERY, ABRUPTIO PLACENTAE, AND FETAL MONITOR ABNORMALITIES FETAL MECONIUM STAINING.

AND YOUR ANSWER WAS: YOU SAID DRUG. YOU JUMPED FROM COCAINE TO DRUG.

MY QUESTION WAS: I'M TALKING ABOUT COCAINE SPECIFICALLY.

AND YOUR ANSWER WAS, DOCTOR, AT LINE 18, COULD YOU READ THAT PLEASE.

A. COCAINE SPECIFICALLY WAS RELATED TO ALL THOSE EXCEPT FOR THE USE OF THE WORD DEPENDENCE.

Q. ALL RIGHT SIR.

SO WITHDRAWAL WAS IN THAT LIST OF COMPLICATIONS, WAS IT NOT?

A. WELL IN READING IT, YES.

Q. OKAY. THANK YOU. IRRITABILITY AS WELL, WAS DOCUMENTED IN 1989, CORRECT?

A. YEAH.

Q. OKAY, RESTLESSNESS, POOR FEEDING AND CRYING AS WELL?

A. YEAH.

Q. AND IMPAIRED NEUROBEHAVIORAL ABILITIES. CAN YOU EXPLAIN TO THE JURY WHAT IMPAIRED NEUROBEHAVIORAL ABILITIES IS?

A. SURE, WHEN A BABY IS FIRST BORN THE BABY COMES WITH CERTAIN CAPABILITIES TO INTERACT WITH THE ENVIRONMENT, TO RESPOND. SO EVEN A BABY WHO IS ONE OR TWO DAYS OLD, WHEN YOU PICK THAT BABY UP AND LOOK THE BABY IN THE EYE, THAT BABY WILL RETURN YOUR GAZE. I'LL INTERACT WITH YOU.

IF THE BABY STARTS GETTING IRRITABLE AND IS CRYING, THE BABY THAT IS ONE, TWO DAYS OF AGE, HAVE THE ABILITY TO COMFORT THEMSELVES. THEY, IF YOU WATCH THEM, THEY TRY TO SUCK ON THEIR HAND. THEY WILL TRY TO BRING THEIR ARMS AND LEGS IN. THOSE ARE NEUROBEHAVIORAL ABILITIES, THE ABILITY TO CALM ONE'S SELF. THE ABILITY TO INTERACT WITH THE ENVIRONMENT AND RESPOND TO THE CARETAKER, THOSE ARE NEUROBEHAVIORS.

Q. AND COCAINE USE DURING PREGNANCY IMPAIRS THE NEUROBEHAVIORAL ABILITIES?

A. YES. COCAINE USE IS ONE OF THE DRUGS THAT CAN DO THAT.

Q. AND IT ALSO CAUSES TREMULOUSNESS IN A NEONATE?

A. IT CAN BE ASSOCIATED WITH TREMULOUSNESS, YES.

Q. AND COCAINE ALSO IS ASSOCIATED WITH INCREASED LABOR AND DELIVERY COMPLICATIONS?

A. YES.

Q. AND CAN YOU TELL THE JURY WHAT THOSE COMPLICATIONS ARE?

A. WELL, WE HAVE TALKED ABOUT SOME OF THE ABRUPTIONS, THE--COCAINE IS ONE OF THE DRUGS ALSO THAT CAN LEAD TO PREMATURITY, PUT A WOMEN INTO LABOR EARLY. TOBACCO CAN DO THAT. AMPHETAMINES. PRECIPITOUS DELIVERY, MEANING THE BABY IS DELIVERED TOO QUICKLY AND CAN SUFFER LOSS OF OXYGEN. SUDDEN RAPID DELIVERY, AMPHETAMINES CAN ALSO DO THAT. THE BABY CAN BE BORN WITH LOW BIRTH WEIGHT, MEANING NOT HAVING GROWN WELL WITHIN—WITHIN THE WOMB. AND COCAINE IS ONE OF THE SUBSTANCES THAT CAN BE ASSOCIATED WITH THAT.

Q. AND FETAL MONITOR ABNORMALITIES, YOU DOCUMENTED THAT THERE WAS AN ADVERSE EFFECT ON FETAL MONITOR ABNORMALITIES CAUSED BY COCAINE USE IN UTERO. CAN YOU EXPLAIN THAT TO THE JURY, PLEASE?

A. THE FETAL MONITOR TRACKS A BABY'S HEART RATE IN UTERO. AND JUST LIKE AN ADULT, WHEN AN ADULT SMOKES A CIGARETTE, HEART RATE CHANGES CAN OCCUR. WHEN AN ADULT USES COCAINE OR AMPHETAMINES, HEART RATE CHANGES CAN OCCUR. SO IF A BABY IS EXPOSED IN UTERO TO THE MOTHER'S--WELL THERE ARE VARIETY OF OTHER REASONS, TOO, BUT IN THE CONTEXT OF SUBSTANCES, IF THE BABY IS EXPOSED IN UTERO TO ANY OF THOSE KIND OF SUBSTANCES THERE CAN BE HEART RATE CHANGES AND FETAL MONITOR ABNORMALITIES.

Q. YOU ALSO DOCUMENTED IN 1989 THAT USE OF COCAINE DURING PREGNANCY AND THE EFFECTS OPEN THE FETUS CAUSE FETAL MECONIUM STAINING. CAN YOU EXPLAIN THAT?

A. MECONIUM IS THE WASTE MATERIAL THAT A BABY COLLECTS IN HIS BOWEL. HE DOES NOT HAVE A BOWEL MOVEMENT IN UTERO EXCEPT UNDER DIRE CIRCUMSTANCES WE WILL GET TO IN A MINUTE, BUT RATHER THE MECONIUM WHICH IS MADE UP OF SWALLOWED AMNIOTIC FLUIDS AND BLOOD AND LINING OF THE BABY'S GUT THAT'S PASSED AFTER, IT'S A BLACK TARRY, STICKY SUBSTANCE THAT IS PASSED WITHIN THE FIRST 24 HOURS AFTER BIRTH. IF A BABY IS NOT GETTING ENOUGH OXYGEN IN THE WOMB, THEN HE LITERALLY WILL START GASPING FOR OXYGEN IN UTERO. AND IF HE BECOMES STRESSED ENOUGH HE WILL THEN PASS THE STOOL, THE MECONIUM IN THE WOMB. AND THERE ARE A NUMBER OF FACTORS AGAIN THAT CAN LEAD TO THAT, COCAINE BEING ONE OF MANY.

Q. LOWER GESTATIONAL AGE AND LOWER NEONATAL BIRTH WEIGHT. YOU TALKED ABOUT THAT A LITTLE BIT EARLIER, BUT THAT IS ALSO ASSOCIATED WITH COCAINE USE DURING PREGNANCY AND ITS SUBSEQUENT EFFECTS ON THE NEONATE, TRUE?

A. LOWER GESTATION AGE IS THE SAME THING AS WE TALKED ABOUT EARLIER, THE PREMATURITY AND THE LOWER NEONATE WEIGHT IS WHAT WE REFER TO AS LOW BIRTH WEIGHT. SO A NUMBER OF FACTORS.

Q. SMALLER BABIES?

A. IN GENERAL, A FULL TERM BABY LESS THAT FIVE POUNDS EIGHT OUNCES.

Q. SPECIFICALLY THE HEAD CIRCUMFERENCE HAVE ALSO BEEN NOTED TO BE SMALLER IN BABIES EXPOSED TO COCAINE IN UTERO?

A. YES. SMALL HEAD CIRCUMFERENCE HAS BEEN SHOWN TO OCCUR MORE COMMONLY IN BABIES WHOSE MOTHERS USED ALCOHOL OR COCAINE OR AMPHETAMINES OR HEROIN DURING PREGNANCY.

Q. COCAINE USE DURING PREGNANCY AND ITS EFFECTS ON THE BABY HAS ALSO BEEN ASSOCIATED WITH SOMETHING CALLED PRUNE BELLY SYNDROME IN 1989, IS THAT TRUE?

A. YES.

Q. COULD YOU EXPLAIN TO THE JURY WHAT PRUNE BELLY SYNDROME IS?

A. THIS IS NOT A VERY PLEASANT--PRUNE BELLY IS, BABIES WHO ARE BORN WITH KIDNEY--A KIND OF KIDNEY PROBLEM THAT THE KIDNEY IS SWOLLEN, IT CAUSES THE BELLY TO SWELL ALSO. THE MUSCLES IN THE ABDOMEN DON'T DEVELOP NORMALLY SO THAT WHEN THE BABY IS BORN THERE IS A LACK OF MUSCLE IN THE ABDOMEN SO THAT THE ABDOMEN IS WRINKLED AND LOOKS LIKE A PRUNE, AND IT'S CALLED PRUNE BELLY SYNDROME.

Q. THAT'S A PRETTY SERIOUS COMPLICATION?

A. THE MOST SERIOUS ASPECT OF IT IS THAT IT CAN BE ASSOCIATED WITH KIDNEY PROBLEMS THAT CAN RESULT IN KIDNEY FAILURE, NEED FOR A TRANSPLANT. PRUNE BELL SYNDROME MOST COMMONLY OCCURS FOR UNKNOWN REASONS, BUT BABIES WHOSE MOTHERS HAVE USED AMPHETAMINES OR COCAINE, CAN--DO HAVE A SLIGHTLY INCREASED RISK OVER THE GENERAL POPULATION.

Q. YOU ALSO, IN 1989, DOCUMENTED THAT COCAINE EXPOSURE IN UTERO WAS ASSOCIATED WITH LIMB REDUCTION DEFORMITIES; IS THAT TRUE?

A. YEAH. A LIMB REDUCTION DEFORMITY IS WHEN A BABY IS BORN MISSING A LIMB. AN ARM OR A LEG OR A TOE OR FINGERS. AND THAT

SPECIFICALLY OCCURS IN THE KIND OF DRUGS THAT CUT OFF BLOOD SUPPLY FOR THE BABY. AGAIN, AMPHETAMINES, COCAINE, MAYBE A SLIGHTLY INCREASED RATE WITH TOBACCO USE.

Q. IN 1989 YOU ALSO DOCUMENTED THAT COCAINE USE DURING PREGNANCY, WHEN THE BABY WAS BORN, THE EFFECTS OF COCAINE OR THE BREAKDOWN OF COCAINE IN THE BLOOD STREAM REMAINED IN THE CHILD'S BLOOD STREAM FOR HOW MANY DAYS, DOCTOR?

A. WELL, THOSE STUDIES WE WERE ACTUALLY LOOKING AT URINE. WE DID NOT MEASURE IN THE BLOOD. YOU HAVE TO BE VERY SPECIFIC HERE. BUT BABIES THAT APPEAR--WE KNOW THEY HAVE MORE IMMATURE LIVERS, SO THEY DON'T BREAK DOWN COCAINE AS RAPIDLY AS AN ADULT WOULD, SO THAT IT APPEARS THAT YOU CAN ACTUALLY FIND LEVELS OF THE BREAKDOWN MATERIALS FROM COCAINE IN THE BABY FOR ABOUT FIVE DAYS AFTER THE BABY WAS BORN.

Q. DR. CHASNOFF, ONE LAST QUESTION ON THE EFFECTS OF THE COCAINE USE IN UTERO.

YOU ALSO REPORTED THAT A ONE-TIME USE OF COCAINE COULD RESULT IN A STROKE TO THE BABY OR THE FETUS, TRUE?

A. YEAH. THERE ARE--AT THAT TIME THERE WERE BEGINNING REPORTS, THE FACT THAT A SINGLE USE OF COCAINE ON A SINGLE OCCASION COULD RESULT IN FAIRLY DIRE CONSEQUENCES,

AS WAS SHOWN ALSO FOR AGAIN OTHER DRUGS LIKE AMPHETAMINES.

Q. IN GENERAL, DOCTOR, SUBSTANCE-ABUSING PREGNANT WOMEN AVOID GETTING PRENATAL CARE; ISN'T THAT TRUE?

A. NO, I CAN'T SAY THAT HAS BEEN SHOWN THROUGH RESEARCH.

Q. THERE IS NO DIFFERENCE BETWEEN AN AVERAGE PREGNANT WOMEN GETTING PRENATAL CARE AND A SUBSTANCE-ABUSING PREGNANT WOMAN?

A. WELL, THE DIFFICULTY IS, YOU ARE GETTING INTO SCIENTIFIC METHODOLOGY. THERE ARE STUDIES THAT SHOW IF YOU TAKE A LARGE GROUP OF WOMEN WHO GET NO PRENATAL CARE, A SIGNIFICANT NUMBER OF THOSE WOMEN HAVE USED DRUGS DURING PREGNANCY. BUT THERE IS NO STUDY--THAT'S CALLED A RETROSPECTIVE STUDY. SCIENTIFICALLY IT IS NOT AS VALID, SEEN AS VALID, THOUGH, AS A PROSPECTIVE STUDY WHERE YOU TAKE A POPULATION OF WOMEN, DRUG USERS AND NON DRUG USERS, AND STUDY THEM PROSPECTIVELY. YOU FIND NO ONE HAS EVER DONE THAT TO KNOW IF TRULY THAT THE DECREASED RATES OF PRENATAL CARE ARE ASSOCIATED WITH THE DRUG USE OR THERE ARE OTHER FACTORS THAT--THAT ARE LEADING TO IT. BUT IT'S--IN GENERAL, ONE OF THE FACTORS THAT MAY IMPEDE PRENATAL CARE IS IF THE

WOMEN IS USING DRUGS. BUT IT MAY NOT BE THE DRUG USE ITSELF, IS WHAT I AM TRYING TO SAY.

Q. IN ONE OF YOUR ARTICLES DID YOU DESCRIBE ONE OF THE SIGNS THAT A PREGNANT WOMEN MAY BE USING SUBSTANCE ABUSE TO BE THAT SHE DELAYED GETTING PRENATAL CARE?

A. THAT IS A RETROSPECTIVE STUDY, YES.

Q. DR. CHASNOFF, IN 1989 YOU TESTIFIED BEFORE CONGRESS ABOUT THE MEDICAL CRISES POSED BY COCAINE USE DURING PREGNANCY, DID YOU NOT?

A. I DID TESTIFY BEFORE CONGRESS. I'M NOT-- I DON'T RECALL I SAID MEDICAL CRISED, BUT --

Q. YOU DID SAY--

A. I—

Q. I'M SORRY.

A. I DON'T REMEMBER THOSE WORDS.

Q. YOU DID SAY THAT THERE WAS AN URGENT NEED TO ESTABLISH PROTOCOLS FOR EARLY RECOGNITION OF SUBSTANCE-ABUSING WOMEN AND PROVIDING TREATMENT AND INTERVENTION PROGRAMS?

A. I DID SAY THAT, YES.

Q. YOU ALSO TESTIFIED THAT THERE HAD BEEN A RAPID RISE IN REPORTED INSTANCES OF COCAINE USE DURING PREGNANCY, DID YOU NOT?

A. YES.

Q. AND THAT IN 1989 SUBSTANCE ABUSE WAS ASSOCIATED WITH APPROXIMATELY 64 PERCENT OF ALL REPORTED CHILD ABUSE CASES?

A. THAT'S RIGHT.

Q. AND YOU ADVOCATED IN THE LATE 1980'S THAT SOMETHING NEED TO BE DONE IMMEDIATELY ABOUT THE PROBLEM OF COCAINE USE DURING PREGNANCY?

A. YES.

Q. AND YOU AGREE WITH ME THAT IT WAS ESSENTIAL FOR MEDICAL PROFESSIONALS TO DEVELOP PROTOCOLS AND CRITERIA TO TEST PREGNANT WOMEN FOR COCAINE USE DURING PREGNANCY?

A. YES.

Q. AND YOU ARE NOT AN ALARMIST IN THE 1980'S ABOUT THE PROBLEMS OF COCAINE USE DURING PREGNANCY?

A. YOU ASKED THAT DIFFERENTLY THAN YOU DID LAST TIME. YES, I AM NOT AN ALARMIST.

Q. AND YOUR RESEARCH WAS NOT FAULTY?

A. OH, NO ONE HAS DONE ANYTHING TO SHOW THAT OUR RESEARCH WAS FAULTY.

Q. AND THE GOAL OF THE INTERAGENCY POLICY, AS YOU UNDERSTAND IT, WAS TO ENHANCE OUTCOMES IN PREGNANCY, TRUE?

A. THAT'S TRUE, I HAVE NO ARGUMENT WITH THE GOAL OF THE POLICY.

Q. IT WAS NOT TO PUT WOMEN IN JAIL?

A. THE STATED GOAL OF THE POLICY WAS TO ENHANCE THE OUTCOMES OF WOMEN AND CHILDREN.

[Tr. 49, line 18 – tr. 50, line 17]

Q. (BY MS. SHOWERS, CONTINUING) DR. CHASNOFF, IN 1989 WHEN YOU TESTIFIED BEFORE CONGRESS THAT YOU ESTIMATED THAT THE NATIONAL COST TO CARE FOR COCAINE EXPOSED INFANTS WOULD BE SOMEWHERE BETWEEN THREE HUNDRED EIGHT-FIVE MILLION AND THREE BILLIONS DOLLARS, ANNUALLY?

MS. DUNN: OBJECTION, YOU HONOR. I DON'T BELIEVE THIS IS RELEVANT.

THE COURT: AS I STATED AT THE SIDEBAR, WE'LL JUST HAVE TO WAIT AND SEE. I'M GOING TO LET THE TESTIMONY COME IN AND THEN SOME LATER DATE IF IT APPEARS THAT IT'S NOT

RELEVANT TO THIS CASE, I'LL INSTRUCT YOU TO DISREGARD IT. BUT FOR THE TIME BEING IT'S IN AND YOU MAY CONSIDER IT TO SUCH EXTENT AS YOU THINK HAS RELEVANCE IN THE CASE. YOU MAY PROCEED.

Q. (BY MS. SHOWERS, CONTINUING) AND THOSE FIGURES WERE BASED ON FIGURES THAT YOU OBTAINED FROM THE GOVERNMENT ACCOUNTING OFFICE?

A. YES.

Q. AND AT THAT TIME YOU FELT THAT THE THREE BILLION DOLLAR FIGURE MAY BE A LOW ESTIMATE AS ONLY ONE-THIRD TO ONE-FOURTH OF THE DRUG EXPOSURES WERE PICKED UP THROUGH DRUG SCREENING?

A. YES

Q. AND THE HYPOTHESIS IN 1989 WAS THAT THE FIGURES FOR CARING FOR THESE INFANTS WAS GOING TO BE ASTRONOMICAL, TRUE?

A. TRUE.

Testimony of Charles Condon
[Tr. 7, line 23 – tr. 8, line 5]

A. SO WHAT I DID WITH THAT INFORMATION IS CONTACTED EVERYONE THAT I COULD THINK OF THAT WOULD HAVE A ROLE IN HELPING TO SOLVE THE PROBLEM. CONTACTED THE POLICE CHIEF, CONTACTED THE PEOPLE WHO RAN THE

DEPARTMENT OF SOCIAL SERVICES, CONTACTED THE PEOPLE AT SUBSTANCE ABUSE, CONTACT MEDICAL UNIVERSITY OFFICIALS, AND WE HAD A MEETING WITH THE INTENTION OF DEVELOPING A MULTIDISCIPLINARY APPROACH TO THIS PROBLEM TO HELP SOLVE IT.

[Tr. 10, line 9 – tr. 11, line 22]

A. PROBLEM PRESENTED TO US AT THAT TIME WOULD BE IS, HOW TO HELP THESE BABIES AND HOW TO STOP THE TOTALLY PREVENTABLE DAMAGE BEING DONE TO THESE INNOCENT LITTLE CHILDREN.

SO, WE MET. AND THE FORCEFUL PEOPLE IN TERMS OF TALKING IN TERMS OF LEGAL INTERVENTION WERE THE DRUG TREATMENT PEOPLE. THE IDEA FROM THEIR PERSPECTIVE, IN FACT THEY SORT OF MOCKED US, WHY DO YOU EXPECT THEM TO DO ANYTHING HAVING SOME SORT OF CONSEQUENCE TO THEIR ACTION, MUCH LIKE AA WOULD HAVE IN TERMS OF BEING RESPONSIBLE FOR WHAT YOU DO.

SO WE DEVELOPED AT THAT TIME, WE GOT INVOLVED AT THE REQUEST OF THE MEDICAL UNIVERSITY WITH A MULTIDISCIPLINARY APPROACH TO SOLVING THIS CRISES. AND IT WENT FROM THERE.

Q. ALL RIGHT, SIR. AND AS THE POLICY EVOLVED, HOW WOULD YOU CHARACTERIZE THE POLICY ITSELF? WHAT WAS GOING TO HAPPEN TO THESE WOMEN?

A. THE POLICY FROM ITS INCEPTION WAS AMNESTY-BASED. I MEAN THE IDEA HERE WAS THAT IF YOU LIVED UP TO SOME VERY BASIC REQUIREMENTS, NUMBER ONE BEING DRUG FREE, DON'T TAKE THE ILLEGAL COCAINE, AND, NUMBER TWO, IF YOU WOULD GO TO FREE DRUG TREATMENT, NOT A THING WOULD HAPPEN TO YOU.

NOW, INITIALLY THE WAY WE DEVELOPED THE POLICY IS THAT WE WANTED TO GET INVOLVED AS EARLY AS POSSIBLE TO PREVENT HARM TO THE CHILDREN.

AS A COROLLARY TO THAT OR THE OPPOSITE TO THAT THINKING WAS INITIALLY IS IF THE DAMAGE IS ALREADY DONE, THAT IS IF THE BABY IS BORN DAMAGED BY COCAINE, SINCE THE DAMAGE IS ALREADY DONE AND THAT COULDN'T BE PREVENTED, TO TREAT THAT SEPARATELY WITH NORMAL CRIMINAL ARREST PROCESS.

THERE IS A STATUTE THAT REQUIRES HEALTH CARE PROFESSIONALS TO REPORT CHILD ABUSE. AND THE INITIAL THINKING THE FIRST COUPLE OF MONTHS WAS THAT THERE WOULD BE A DISTINCTION. WHEN IT WAS IN UTERO, THE CHILD IN UTERO, IF YOU COULD PREVENT THE HARM, IT WAS A TOTALLY AMNESTY-BASED PROGRAM. AFTER THAT IF THE CHILD WAS BORN WITH CRACK COCAINE, USE THE NORMAL ARREST FUNCTIONS OF THE CRIMINAL JUSTICE SYSTEM AND TREAT IT LIKE A REGULAR CRIMINAL CASE.

WE QUICKLY CHANGED THAT POLICY AT THE REQUEST OF THE DOCTORS, PRIMARILY THE NEONATOLOGISTS AT MUSC BECAUSE THEY THOUGHT THERE WAS ADDICTION THERE.

Testimony of James B. Edwards
[Tr. 578, lines 15-20]

Q. (BY MR. HOOD, CONTINUING) WOULD YOU PLEASE TELL US, DON'T GIVE US THE NUMBER, WHAT THE FACTORS WERE, FROM YOUR PERSPECTIVE OF THE MEDICAL UNIVERSITY FOR THIS POLICY?

A. WELL, THE EXPENSE OF THE CARE OF THESE BABIES WAS ONE OF THE FACTORS THAT I TOOK INTO CONSIDERATION WHEN WE WERE TALKING ABOUT THE DEVELOPMENT OF THIS POLICY.

[Tr. 579, lines 14-17]

Q. WHAT IS THE GOAL OF THIS POLICY? WHAT IS HOPED TO BE ACHIEVED BY AND WHAT WAS HOPED TO BE ACHIEVED BY THIS POLICY?

A. TO PROTECT THESE INNOCENT UNBORN CHILDREN WAS THE GOAL OF THIS POLICY.

Testimony of Joseph C. Good
[Tr. 188, line 16 – tr. 189, line 10]

Q. AND WHEN THEY WERE REFERRED TO CHARLESTON COUNTY SUBSTANCE ABUSE, WHAT WAS THE REASON FOR THAT?

A. WELL, THAT WAS THE CARROT AND STICK. WHAT OUR CONCERN WAS, THIS IS NOT SUPPOSED TO BE A PUNITIVE POLICY WHERE WE WENT OUT AND PUNISHED PEOPLE FOR DOING SOMETHING, EVEN THOUGH WE KNEW THE ACTIVITY WAS ILLEGAL. WHAT WE WERE TRYING TO DO IS GIVE THOSE BABIES A CHANGE TO BE BORN NORMAL.

AND WHAT WE WERE TELLING THE MAMAS IS THAT, LOOK, WE'RE GOING TO TRY TO HELP YOU, BUT OUR MAIN CONCERN FRANKLY IS THAT UNBORN BABY. IF YOU WILL GO TO CHARLESTON SUBSTANCE ABUSE, YOU WILL LET THEM HELP YOU, YOU CAN'T KICK THIS ON YOUR OWN YOU NEED PROFESSIONAL HELP, IF YOU MAKE APPOINTMENTS THERE, IF YOU GO TO PRENATAL CARE AND GIVE THAT BABY A CHANCE TO BE BORN HEALTHY, WE ARE GOING TO FORGET ABOUT ALL OF THIS OTHER STUFF. THAT WAS THE CARROT. YOU KNOW, IF YOU GIVE YOUR BABY A CHANCE, LET'S WIPE THE SLATE CLEAN AND FORGET ABOUT IT. ON THE OTHER HAND IF YOU PERSIST IN DOING THAT, WE GOT TO TAKE SOME ACTION, WE GOT TO FORCE YOU INTO TREATMENT OR WE GO TO, LORD FORBID ME, PUT YOU IN JAIL WHERE YOU CAN'T HAVE THOSE DRUGS UNTIL THAT BABY IS BORN.

Testimony of Edgar O. Horger, M.D.
[Tr. 4, line 13 – tr. 5, line 17]

Q. DURING THE COURSE OF YOUR WORK AT THE MEDICAL UNIVERSITY WAS THERE A TIME PERIOD IN WHICH YOU BECAME AWARE OR STARTED NOTICING WITHIN THE POPULATION THAT YOU WERE SERVING AN INCREASE IN THE USE OF COCAINE?

A. YES I THINK SO.

Q. AND ABOUT WHEN WAS THAT?

A. PROBABLY IN SOMETIME IN 1988. IT MAY HAVE BEGUN IN 1987. WE WERE NOTICING NATIONWIDE WHAT WAS ULTIMATELY CLAIMED TO BE A CRISES IN TERMS OF COCAINE AND ITS PROBLEMS IN PREGNANCY. AND WE CAME TO REALIZE, GEE, WE HAVE THIS HERE ALSO.

Q. AND SO IS IT FAIR TO SAY THAT WHAT YOU BROUGHT IT TO YOUR ATTENTION INITIALLY WAS HEARING THE INFORMATION THAT OTHER PLACES WERE HAVING A PROBLEM WITH THIS?

A. I THINK THIS PROBABLY BROUGHT THE REALIZATION TO US THAT WE WERE DEALING WITH THE SAME TYPE OF PROBLEMS THAT WE WERE GOING OFF TO MEETINGS, READING IN JOURNALS, THAT WE GOT THESE SAME TYPES OF PROBLEMS INCREASING IN OUR HOSPITAL AND PERHAPS WE'RE DEALING WITH THE SAME COCAINE.

Q. SO YOU TOOK THAT INFORMATION BACK TO THE PEOPLE YOU WERE TRYING TO SERVE AND STARTED WATCHING PERHAPS MORE CAREFULLY

NOW FOR SOME OF THE SAME SIGNS, IS THAT FAIR?

A. I THINK THIS IS TRUE. I THINK PERHAPS THE VERY FIRST TIME IT CAME TO LIGHT WAS FOLLOWING A CASE OF AN ABRUPTIO PLACAENTA WITH A--I TRULY CAN'T RECALL WHETHER IT WAS A DEAD FETUS AS A RESULT OF THE ABRUPTION, BUT IT WAS A DEFINITE ABRUPTION OF THE PLACENTA. AND I MADE THE COMMENT THAT, GEE, I JUST HEARD SOMEONE AT SUCH AND SUCH A MEETING TALKING ABOUT THIS. AND SOMEONE SAID, WELL, MAYBE WE SHOULD SCREEN FOR COCAINE. WE SCREENED AND IT WAS POSITIVE.

[Tr. 6, line 2 – tr. 7, line 4]

A. I THINK IT WAS A PARTICULAR REVELATION TO ME THAT, GEE, WE HAVE THE SAME PROBLEMS THAT THEY HAVE UP IN NEW YORK AND CALIFORNIA.

Q. WAS THERE ANYTHING DURING THIS EARLY TIME THAT YOU'RE TALKING ABOUT, COMING TO BE AWARE OF A PROBLEM WITHIN THE COMMUNITY THAT YOU SERVED, FOR USING COCAINE, WAS THERE ANYTIME WHEN YOU DID UNIVERSAL TESTING TO ESTABLISH WHAT--WHAT THE FULL USE MIGHT HAVE BEEN?

A. NO, WE NEVER DID ANY UNIVERSAL TESTING?

Q. AND WHAT IS UNIVERSAL TESTING?

A. I WOULD ASSUME THAT YOU REFER TO TESTING EVERY PATIENT, SUCH AS THE DRUG PREVALENT STUDY, THAT WAS BROUGHT INTO EVIDENCE EARLIER.

Q. AND WOULD IT BE FAIR TO SAY THEN WHAT YOU BASE YOUR INFORMATION ON IN TERMS OF THERE BEING AN INCREASE IN USE OF COCAINE BY THE WOMEN THAT YOU WERE SERVING OR CLINICAL OBSERVATIONS?

A. I THINK THAT WE'RE GOING IN THE SAME DIRECTION. I BELIEVE IT WAS CLINICAL OBSERVATIONS THAT SAID PERHAPS THIS PROBLEM IS CAUSED BY COCAINE. PERHAPS WE SHOULD BE SCREENING FOR DRUG ABUSE. WE DID NOT KNOW THAT WE WERE DEALING WITH COCAINE. WE CAME TO THE REALIZATION AFTER HEARING OTHERS TALKING ABOUT IT, THAT WE DO SEEM TO HAVE HAD MORE ABRUPTIONS OF THE PLACENTA IN THE PAST SIX OR EIGHT OR TEN MONTHS. WE DO SEEM TO HAVE MORE PRE-TERM LABORS THAT WE ARE UNSUCCESSFUL IN STOPPING WITH OUR USUAL TREATMENT TO STOP PRE-TERM LABOR. PERHAPS THERE IS A REASON FOR IT, SOMETHING THAT IS DRIVING IT THAT WE HAD NOT BEEN SUSPICION OF PREVIOUSLY.

[Tr. 9, line 5 – tr. 10, line 4]

Q. AND IN APRIL OF 1989, DID YOU FORMALIZE SOME KIND OF PROTOCOL WITHIN YOUR DEPARTMENT FOR THE SCREENING OF UDS FOR SUSPECTED USE OF COCAINE BY PREGNANT WOMEN?

A. YES. I FEEL LIKE BY THAT TIME WE HAD SEEN THAT MORE AND MORE OF OUR SUSPICIONS OF POSITIVE--OF PATENTS WHO MAY HAVE BEEN POSITIVE FOR DRUG USE WERE BORNE OUT BY THE DRUG TESTING. BY THE URINE DRUG SCREENS. CONSEQUENTLY I FEARED THAT WE BETTER GET THIS THING ON A REGULAR STRAIGHTFORWARD, NO QUESTIONS PROTOCOL, LET'S SCREEN THESE PATIENTS WHO HAVE THESE INDICATIONS. I WANTED TO REMOVE ANY SUBJECTIVITY FROM IT. I HATED THE POSSIBILITY OF SOMEONE SAYING, WELL, SUSAN DUNN, TO USE AN EXAMPLE, LOOKS THIS SHE MIGHT HAVE USED A DRUG, LET'S SCREEN HER. WE WANTED TO AVOID THAT AND PUT IT STRICTLY ON A PROTOCOL BASIS.

Q. AND AT THE TIME IN APRIL OF 1989 WHEN THE PROTOCOL WAS ADOPTED--PROTOCOL IS JUST CONSISTED A LIST, THESE ARE THE THINGS THAT YOU SHOULD TEST FOR?

A. CORRECT. SIX INDICATORS.

Q. AND IF I READ THOSE SIX TO YOU WOULD YOU REMEMBER THEM?

A. I THINK I CAN REMEMBER THEM WITHOUT.

Q. LET ME LET YOU DO IT THEN.

A. I THINK IT WAS KNOWN SUBSTANCE ABUSE OR KNOWN HISTORY OF SUBSTANCE ABUSE. AND ABSENCE OF PRENATAL CARE. INTRAUTERINE

FETAL DEATH. INTRAUTERINE FETAL GROWTH RETARDATION. PRE-TERM LABOR AND ABRUPTIO PLACENTA.

[Tr. 61, lines 19-21]

Q. (BY MR. HOOD, CONTINUING) WHILE YOU WERE THERE AND THE POLICY WAS BEING FOLLOWED, WHAT WAS YOU OPINION AS TO THE SUCCESSFULNESS OF THE POLICY?

[Tr. 62, lines 9-13]

A. MY OPINION WAS THAT WE WERE ENCOUNTERING FEWER OF THE COMPLICATIONS THAT WE HAD PREVIOUSLY BEEN ATTRIBUTING TO DRUG USE AND WERE--WERE HAVING REPORTS OF FEWER POSITIVE DRUG SCREENS IN THE SIX OR SEVEN MONTHS THAT I WAS HERE AFTER THE DRUG--AFTER THE DRUG POLICY WENT INTO EFFECT.

[Tr. 67, line 1-11]

Q. HAVEN'T THERE BEEN REPORTS TO THE MEDICAL LITERATURE WHAT ONE DOSE OR ONE USE OF COCAINE COULD DO TO THE BABY?

A. BACK IN THE EARLY MIDDLE OR LATE EIGHTIES WHEN WE WERE FIRST READING MORE AND MORE, AND LEARNING MORE AND MORE ABOUT THE PROBLEM, THERE WERE ANY NUMBER OF REPORTS THAT SAID THIS PATIENT HAS SUCH AND SUCH A CATASTROPHE, IMMEDIATELY

FOLLOWING OR SHORTLY FOLLOWING HER ONLY USE OF COCAINE.

Q. YOU TALKED ABOUT COCAINE WRECKING PREGNANCIES. AFTER THE POLICY, DID THIS WRECKING SUBSIDE?

A. I THINK IT DECREASED CONSIDERABLY. THERE IS NO QUESTION BUT THAT WE STILL SEE PROBLEMS FROM COCAINE USE.

Testimony of Herbert D. Kleber, M.D.
[Tr. 720, line 9 – tr. 721, line 25]

Q. FROM YOUR ATTENDANCE AT THE MEETING AT THE MEDICAL UNIVERSITY AND YOUR INVOLVEMENT IN THE INTERAGENCY POLICY, WHAT WAS YOUR IMPRESSION OF THE GOAL OF THE POLICY?

A. THE WAY THAT--MY OVERALL RECOLLECTION OF THAT WAS THAT THE EFFORTS PRIOR—PRIOR EFFORTS TO ENCOURAGE WOMEN TO SEEK HELP EARLIER, AND IN TERMS OF DEALING WITH THEIR ADDICTION HAVE--HAD NOT BEEN SUCCESSFUL TO THE--AT LEAST TO THE EXTENT THAT PEOPLE WERE HOPING. AND THIS AS A LAST RESORT WAS OFFERED AS A METHOD TO INTERVENE IN THE ADDICTION PROCESS AND GET SOMEONE'S ATTENTION AT A POINT WHERE MAYBE USING THAT AS A LEVERAGE, USING THE ISSUE OF THAT INTERVENTION AS LEVERAGE TO MAKE THEM SEEK TREATMENT THAT THEY WOULD NOT HAVE SOUGHT OTHERWISE.

THE PROCESS OF ADDICTION IS SUCH THAT DENIAL IS ONE OF THE KEY FEATURES, ONE OF THE KEY SYMPTOMS. AND A PERSON LEFT TO THEIR OWN RESOURCES, AS MANY OF US MIGHT HAVE WITNESSED, RARELY ADMIT ADDICTION. THEY WILL SACRIFICE A LOT OF THINGS PRIOR TO ADMITTING THAT. SO THIS WAS THE WAY TO INTERVENE, HOPEFULLY GET SOME WOMEN SOME HELP IN THAT ADDICTION PROCESS BEFORE IT CAUSED EVEN GREATER HARM TO THEM AND OTHERS.

Q. YOU MENTIONED LEVERAGING. COULD YOU EXPLAIN WHAT YOU MEAN BY LEVERAGING TO THE JURY?

A. AGAIN, IN THE EXPERIENCE THAT I HAVE HAD, AND PRIOR TO BEING AT THE CHARLESTON COMMISSION, I HAD WORKED IN THE ADDICTION FIELD AS AN--IN AN ADMINISTRATIVE CAPACITY FOR A NUMBER OF YEARS PRIOR TO THAT. IT'S NOT COMMON, I WON'T SAY IT NEVER HAPPENS, BUT IT'S NOT COMMON FOR SOMEONE ON THEIR OWN PERFECT FREEWILL TO COME IN AND SAY I HAVE AN ADDICTION AND I NEED SOME HELP. USUALLY IT'S A FAMILY MEMBER, A PHYSICIAN OR A JUDGE OR AN EMPLOYER. VERY FREQUENTLY AN EMPLOYER. A PERSON WILL HOLD THE JOB LONGER THAN THEY WILL HOLD ONTO A FAMILY AND A HOUSE.

SO BY INTERVENING INTO THAT, BY SAYING TO SOMEONE EITHER YOU GET--EITHER YOU ADDRESS THIS ADDICTION, EITHER YOU GET SOME HELP OR YOUR JOB IS AT JEOPARDY, EITHER YOU

GET SOME HELP OR THE MARRIAGE IS OVER, OR YOU GET SOME HELP OR YOUR HEALTH IS GOING TO SUFFER OR YOU GO TO JAIL, THOSE ARE INTERVENING TECHNIQUES THAT SOMETIMES IT TAKES TO GETS SOMEBODY'S ATTENTION, OTHERWISE THEY WILL NOT LOOK AT IT CLOSELY ENOUGH THEMSELVES TO BREAK THROUGH THAT DENIAL AND UNDERSTAND THE LEVEL OF THAT PROBLEM.

[Tr. 839, line 21 – tr. 840, line 13]

A. WE HAVE A SAYING IN THE FIELD OF DRUG ABUSE THAT DRUG USE IS A PREVENTABLE DISORDER AND DRUG ADDICTION IS A TREATABLE DISEASE, SO THAT WE BELIEVE THAT WE KNOW HOW, NOT AS WELL AS WE WOULD LIKE OR OFTEN AS WE WOULD LIKE TO TREAT DRUG ADDICTION, BUT MUCH OF THE TIME IT CAN BE SUCCESSFULLY TREATED. HOWEVER, THE NATURE OF THE DISORDER IS SUCH THAT GIVEN THE PLEASURABLE EFFECTS OF THE DRUGS THAT WE'RE DEALING WITH, AND THE FACT THAT THEY CHANGE THE REWARD SYSTEM OF THE BRAIN, OFTEN INDIVIDUALS ARE NOT INITIALLY WILLING TO COME TO TREATMENT VOLUNTARILY. THEY OFTEN DON'T WANT TO GIVE UP THE FEELINGS THAT THE DRUGS CAN PRODUCE.

SO OVER THE PAST 30 YEARS THERE HAVE BEEN A NUMBER OF INSTANCES WHERE INDIVIDUALS HAVE BEEN COERCED INTO TREATMENT. NOT--IN MANY WAYS PROBABLY MOST ADDICTS ARE COERCED INTO TREATMENT. THE ISSUE IS ONLY WHO IS DOING THE COERCING.

WE OFTEN THING OF COERCIVE TREATMENT AS PRIMARILY SOMETHING DONE BY THE CRIMINAL JUSTICE SYSTEM, BUT PROBABLY THE VAST MAJORITY OF ADDICTS THAT I TREAT ARE THERE BECAUSE AN EMPLOYER HAS SAID GET TREATMENT OR I'M GOING TO FIRE YOU. A SPOUSE HAS SAID GET TREATMENT OR I'M GOING TO LEAVE YOU. OR A JUDGE SAID GET TREATMENT OR YOU WILL GO TO JAIL. SO THAT PROBABLY THE LARGE MAJORITY OF PATIENTS COME INTO TREAMENT THROUGH SOME SORT OF COERCIVE INTENT.

Q. DOES COERCIVE TREATMENT MEAN FORCED TREATMENT OR MANDATORY TREATMENT?

A. WELL, THE LANGUAGE HERE IS A LITTLE SLIPPERY. I DISTINGUISH BETWEEN COERCED TREATMENT AND MANDATORY TREATMENT. MANDATORY TREATMENT IS WHEN SOMEONE SAYS YOU MUST HAVE TREATMENT. COERCIVE TREATMENT SAYS YOU HAVE A CHOICE. YOU HAVE TO HAVE TREATMENT OR CHOOSE THE ALTERNATIVE. THE CONTINGENCY.

SO IN THE CASE OF THE EMPLOYEE, COERCIVE TREATMENT WOULD SAY YOU HAVE TO HAVE TREATMENT OR YOU'LL BE FIRED. OR THE SPOUSE WHO SAYS YOU HAVE TO HAVE TREATMENT OR I'LL LEAVE YOU. SO THE TREATMENT IS COERCED BECAUSE YOU HAVE COERCION THERE, BUT THEY DO HAVE THE OPINION OF TAKING THE ALTERNATIVE SAYING I DIDN'T LIKE THE JOB ANYWAY, YOU KNOW, I'M GOING TO LEAVE THAT JOB. SO WHEREAS

MANDATORY TREATMENT YOU MUST GO INTO THAT TREATMENT. YOU HAVE NO CHOICE. SO, THAT'S AT LEAST HOW I USE THE TERM.

Q. FROM YOUR REVIEW OF THE INTERAGENCY POLICY, WAS IT MANDATORY TREATMENT OR COERCIVE TREATMENT?

A. IT'S MY UNDERSTANDING THIS WAS COERCED TREATMENT.

[Tr. 852, line 20 –tr. 853, line 20]

Q. (BY MS. SHOWERS, CONTINUING) BACK TO THE PREVALENCE OF COCAINE DURING THE TIME PERIOD, DR. KEBLER, WHAT TIME PERIOD ARE YOU TALKING ABOUT?

A. THE TIME PERIOD OF THE LATTER PART OF THE 1980'S.

Q. GO AHEAD WITH YOUR ANSWER ABOUT THE PREVALENCE OF COCAINE.

Q. PERHAPS WHAT I SHOULD DO IS LAY THE STAGE FOR HOW WE GET THERE. HOW DO WE KNOW WHAT IS GOING ON ARE THREE MAJOR DATA SOURCES. ONE, THE HOUSEHOLD SURVEYS WHICH GATHERS DATA ABOUT DRUG USE, PEOPLE WHO LIVE IN HOUSEHOLD. THE HS SURVEYS WHICH LOOK AT DRUG USE AMONG COLLEGE STUDENTS. AND THE EMERGENCY ROOM DATA WHICH LOOKED AT THE AMOUNT OF DRUG USE AMONG PEOPLE COMING TO EMERGENCY ROOMS,

THE REASONS THEY COME TO THE EMERGENCY ROOMS AS FAR AS ILLICIT DRUGS ARE CONCERNED.

ALL OF THOSE SURVEYS INDICATED THAT DURING THE 1980'S, THERE WAS A SHARP RISE IN COCAINE USE. BY THE MID-80'S, FOR EXAMPLE, THE HOUSEHOLD SURVEY INDICATED THAT SIX MILLION AMERICANS WERE USING COCAINE DURING THE PAST 30 DAYS. THERE WERE--

Q. HOW MANY DID YOU SAY?

A. SIX MILLION AMERICANS WERE USING COCAINE CURRENTLY. CURRENTLY DEFINED IN THE PAST 30 DAYS. THERE WAS A MAJOR CONCERN SINCE MANY OF THESE WOMEN, THAT MANY OF THESE WERE WOMEN, THAT MANY OF THEM WERE TAKING COCAINE DURING PREGNANCY, THAT THERE WOULD BE A MAJOR PROBLEM WITH IMPAIRED NEWBORNS. AND THAT'S WHY WE MADE PREGNANT ADDICTS ONE OF OUR THREE MAJOR CONCERNS.

[Tr. 859, lines 16-24]

Q. (BY MS. SHOWERS) HAVE YOU REVIEWED THE INTERAGENCY POLICY, THE ONE DEVELOPED BY THE MUSC, THE SOLICITOR'S OFFICE AND THE CHARLESTON CITY POLICE DEPARTMENT.

A. YES I HAVE.

Q. AND HAVE YOU REACHED OPINIONS ABOUT THAT POLICY, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY, MOST PROBABLY?

A. YES. I FEEL THAT THE POLICY WAS A REASONABLE RESPONSE TO THE PROBLEM OF COCAINE-ABUSING PREGNANT WOMEN AT THAT PERIOD OF TIME.

Testimony of Roger Newman, M.D.
[Tr. 211, line 17 – tr. 212, line 21]

Q. NOW, THIS LAWSUIT IS ABOUT WHAT WE CALL THE INTERAGENCY POLICY. I WANT TO TELL THE JURY FIRST BEFORE THE POLICY IN LATE '89, IF A WOMEN CAME IN AND HAD MEDICAL COMPLICATIONS WHAT WAS DONE? I WANT TO TALK ABOUT WHAT WAS BEING DONE IN—AT THE MEDICAL UNIVERSITY BEFORE THE POLICY.

A. IN REGARD TO DRUG TESTING OR GENERAL TREATMENT?

Q. WELL, NO. LET'S TALK ABOUT DRUG TESTING.

A. WELL, IF A PATIENT CAME INTO THE HOSPITAL THAT HAD AN OBSTETRICAL COMPLICATION THAT WE FELT WAS RELATED TO THE POTENTIAL OF DRUG ABUSE, WE WOULD PERFORM DRUG TESTING, URINE DRUG TESTING ON THAT PATIENT TO DETERMINE IF DRUGS WERE INVOLVED. WE DID IT NOT UNDER A PROTOCOL

AT THAT POINT BUT MORE JUST AS A PART OF CLINICAL DECISION MAKING.

AT SOME POINT, I THINK PROBABLY IN '89, WE DID PUT TOGETHER A LIST JUST TO TRY TO MAKE IT MORE UNIFORM OF WHAT WE FELT WERE THE INDICATORS FOR WHICH WE SHOULD OBTAIN URINE DRUG TESTS. AND AGAIN THIS WAS PRIOR TO INSTITUTING THE POLICY. WE WERE RECOGNIZING WHAT WE FELT WERE MORE AND MORE PATIENTS EXPERIENCING, USING COCAINE DURING PREGNANCY AND WE FELT AND IT WAS IN OUR OPINION RELATED TO A NUMBER OF DIFFERENT OBSTETRICAL COMPLICATIONS. WHAT WE PROBABLY SAW THE MOST WERE ABRUPTIO PLACENTA, STILLBIRTHS AND PREMATURE LABOR THAT DIDN'T RESPOND TO THE TYPICAL TREATMENT THAT WE USED. AND, AGAIN, THESE ARE VERY SERIOUS.

AND ALSO THE PEDIATRICIANS WERE ALSO TELLING US THAT IN THEIR EXPERIENCE THEY WERE DEALING WITH MORE AND MORE BABIES THAT WERE HAVING WITHDRAWAL TYPE SYNDROME AND OTHER PROBLEMS THEY FELT WAS ATTRIBUTED TO COCAINE OR OTHER DRUGS WELL. BUT, WE WERE EXPERIENCING, WE THOUGHT, A SIGNIFICANT INCREASE IN THIS. AT THE SAME TIME THE MEDICAL LITERATURE THERE WAS MORE AND MORE BEING WRITTEN ABOUT AS TO CONSEQUENCE OF DRUG ABUSE AND PREGNANCY.

AND IN MANY OCCASIONS IT BECAME VERY CLINICALLY NECESSARY TO HAVE THIS

INFORMATION. HOW TO DEAL WITH PREMATURE LABOR IN THIS SITUATION WAS DIFFERENT. THEY DIDN'T RESPOND TO THE TYPICAL MEDICATION WE USED. THEY AT SOME POINT, IF WE USED THE TYPICAL MEDICATION WE USED, IN A PATIENT WHO WAS ON COCAINE, THAT INCREASED THE MATERNAL RISK OF THE DRUG. THERE WERE REPORTS OF WOMEN BEING TREATED WITH DRUGS SUCH AS RITORINE AND TERBUTALINE, WHICH ARE TYPICALLY USED FOR PRE-TERM LABOR, WHICH IS CARDIAC STIMULANT, AND THAT BEING USED ON TOP OF A PATIENT WHO HAD USED COCAINE, WHICH IS ALSO A CARDIAC STIMULANT, RESULTING IN HEART ATTACKS AND STROKES AND THINGS LIKE THAT. SO WE WERE CONFRONTING THESE CASES OF PREMATURE LABOR AND WE WERE COLLECTING THAT INFORMATION.

STILL BIRTHS WE COLLECTED. EXCUSE ME, WHEN THERE WERE STILLBIRTHS OR ABRUPTIO PLACENTA, WE WOULD GET THIS INFORMATION AND TRY TO IDENTIFY THE CAUSE. IF A WOMEN LOST A BABY, SHE WAS GOING TO BE INTERESTED IN KNOWING WHY, WE WERE INTERESTED IN KNOWING WHY, AND WE WOULD WANT TO DO WHAT WE COULD TO PREVENT IT. IN FUTURE PREGNANCIES THERE IS A RISK OF RECURRENCE OF STILLBIRTH, AND TO BE ABLE TO DEAL WITH THAT RISK YOU HAVE TO KNOW WHAT CAUSED IT. AND COCAINE WAS PROVING TO BE ONE OF THE THINGS ASSOCIATED WITH IT.

WE ALSO EXPERIENCE, AGAIN, WOMEN WITH ABRUPTIO PLACENTA. I VERY VIVIDLY

REMEMBER A PATIENT WHO WE HAD BEEN FOLLOWING IN OUR HIGH-RISK CLINIC HAD HAD A VISIT WITHIN THE LAST SEVERAL DAYS FOR WHATEVER REASON HAD WANTED TO BE ADMITTED AND PUT INTO LABOR, I CAN'T REMEMBER THE REASON WHY. WE DIDN'T FEEL LIKE IT WAS NECESSARY AT THAT POINT. AND SHE CAME BACK WITH AN ABRUPTIO PLACENTA AND I BELIEVE HER BABY DIED. AND SHE WAS VERY ANGRY TELLING US THAT WE SHOULD HAVE PUT HER IN THE HOSPITAL LAST WEEK WHEN YOU FELT LIKE SHE SHOULD HAVE BEEN DELIVERED AND THAT IT WAS ALL OUR FAULT. AND FORTUNATELY IN THAT CASE FOR US, NOT FOR HER OR THE BABY, SHE PROVED TO BE COCAINE POSITIVE. AND SHE—WE DIDN'T HEARD MUCH FROM HER AFTER THAT. BUT I HAD NO DOUBT WE WERE GOING TO BE SUED BY HER FOR MALPRACTICE UNTIL WE HAD THAT INFORMATION.

SO HAVING THAT INFORMATION HAD CLINICAL IMPORTANCE, IT HAD IMPORTANCE FROM KNOWING THE CASE OF WHY THINGS HAPPEN, BOTH FOR THE PATIENTS' BENEFIT AND OUR BENEFIT TO KNOW WHY THINGS HAPPENED, SO WE TESTING THE PATIENT AT THAT POINT IN TIME.

Q. AND THAT'S UDS, URINE DRUG SCREENS?

A. YES, SIR.

Q. OKAY.

A. I WOULD ALSO ADD THAT PEDIATRICIANS WERE TESTING AS WELL BECAUSE THEIR MANAGEMENT OF NEWBORNS WERE AFFECTED BY WHETHER OR NOT THEY WERE GOING TO HAVE A COCAINE WITHDRAWAL OR OTHER MANIFESTATIONS OF COCAINE EXPOSURE.

[Tr. 219, lines 12-23]

Q. BEFORE THE POLICY WERE THEY SUBJECTIVE, THAT IS, UP TO INDIVIDUAL DOCTORS' CHOICE WITH REGARD TO URINE DRUG SCREEN?

A. YES, SIR. ONE OF THE SPECIFIC REASONS THAT WE CHOSE TO INSTITUTE A PROTOCOL AS TO WHO WERE APPROPRIATE CANDIDATES FOR SCREENING IS BECAUSE WE FELT THAT WOULD BE BETTER, MORE EVENHANDED THAN TO LEAVE IT UP TO THE SUBJECTIVITY OF INDIVIDUAL PRACTITIONERS.

Q. AND ONCE THE POLICY WAS PUT INTO EFFECT, WHICH I THINK IS NOVEMBER OF '89, FROM THAT TIME FORWARD WAS THERE A SPECIFIC MEDICAL CRITERIA BY WHICH PATIENTS WERE TESTED?

A. YES SIR. SEVERAL MEDICAL CRITERIA.

[Tr. 220, lines 1-4]

A. NO. NO, SIR. AS I SAID, WE SPECIFICALLY PUT THE LIST OF INDICATORS TOGETHER AND

INSISTED THAT LIST OF INDICATORS BE PART OF THE POLICY TO INSURE THAT PEOPLE WERE TESTED FOR MEDICAL INDICATIONS AND NOT FOR OTHER EXTRANEOUS INDICATIONS.

[Tr. 220, lines 13 – tr. 226, lines 12]

A. WELL THE INDICATIONS THAT WE USED, THESE ARE THE INDICATIONS THAT WERE DEVELOPED FOR THE POLICY THE M-7 POLICY. THE INDICATION THAT WERE USED PRIOR TO THE M-7 POLICY BASICALLY ARE THESE LISTED UNDER "A" WHICH WERE THE OBSTETRICAL INDICATORS. AND THEN FOR THE PURPOSE OF THE POLICY WE ADDED THESE DOWN HERE WHICH WERE THE INVOLVEMENT OF PEDIATRICIANS AND NEONATOLOGISTS.

THE PATIENTS THAT WE FELT REQUIRED SCREENING WOULD BE PATIENTS THAT PRESENTED FOR LABOR--IN LABOR OR TO ON DELIVERY SUITE WHO DID NOT AVAIL THEMSELVES TO ANY PRENATAL CARE AT ANY POINT DURING THAT PREGNANCY.

THEN THESE TWO HERE WOULD REALLY BE SOMEWHAT ANALOGOUS TO THAT. THESE WERE PATIENTS WHO EITHER HAD WHAT CALLED LATE PRENATAL CARE, WHICH FOR OUR PURPOSES WERE WOMEN WHO DID NOT COME FOR PRENATAL CARE UNTIL AFTER 24 WEEKS GESTATION, SO THIS IS REALLY THE LAST THIRD OF THEIR PREGNANCY, AND THEN PATIENTS WHO HAD INCOMPLETE PRENATAL CARE. AND WE USED THE CRITERIA OF PATIENTS WHO MAY HAVE

COME FOR PRENATAL CARE EARLY BUT THAT HAD HAD LESS THAN SIX PRENATAL CARE VISITS.

Q. LET ME STOP YOU. US MEN DON'T UNDERSTAND THIS. HOW MANY WEEKS IS NORMAL PREGNANCY?

A. PREGNANCY LASTS 42 WEEKS. TYPICALLY DIVIDED INTO TRIMESTERS, FIRST, SECOND, THIRD. FIRST WOULD BE UP TO 13 WEEKS AND SECOND UP TO 26 WEEKS, AND THE THIRD TRIMESTER WAS DELIVERY.

Q. AND WHEN IS A CHILD CONSIDERED VIABLE AS TO THE FETUS?

A. FOR THE PURPOSES OF THIS POLICY WE USED 27 WEEKS. BABIES ARE CERTAINLY VIABLE AS EARLY AS 26 AND SOMETIMES 25 WEEKS, ALTHOUGH AT THAT POINT IT'S MUCH MORE RISKY TO BE BORN AND MOST OF THOSE BABIES WILL PROBABLY DIE AT 24 TO 25 WEEKS. BUT BY 27 WEEKS THERE IS AN EXCELLENT CHANCE OF SURVIVAL. I THINK THE MEDICAL UNIVERSITY HAS ABOUT 80 PLUS OR 80 PERCENT FOR SURVIVAL AT 27 WEEKS, WHICH WOULD BE ROUGHLY A LITTLE OVER TWO POUNDS.

Q. TWO POUNDS?

A. YES.

Q. THE FOURTH INDICATION IS PROBABLY THE MOST COMMON COMPLICATION OF COCAINE ABUSE IN PREGNANCY, WHICH IS ABRUPTIO

PLACENTA.--THE PLACENTA IS AN ORGAN THAT PROVIDES THE EXCHANGE OF OXYGEN AND NUTRIENTS FOR THE BABY AND THE MOM. AND UNDER THE INFLUENCE OF COCAINE, FOR INSTANCE, THAT CAUSES AN INTENSE HYPERTENSIVE EPISODE IN THE USE OF COCAINE. BLOOD PRESSURE GOES UP DRAMATICALLY WHEN YOU TAKE COCAINE. AND THAT BLOOD PRESSURE CAN CAUSE A SEPARATION FROM THE PLACENTA FROM THE UTERUS. BLEEDING BEGINS AND AS THE BLEEDING CONTINUES IT FORMS A CLOT THAT JUST GRADUALLY SEPARATES THE PLACENTA. SOMETIMES IT CAN BE SMALL AND THE BABY WILL SURVIVE IT AND THEN USUALLY IF THE ABRUPTION INVOLVES HALF OF THE PLACENTA OR MORE, IT WILL BE FATAL.

Q. IS THAT A MEDICAL CRISES?

A. OH YES. I MEAN, AGAIN HALF THE TIME OR MORE IT CAN BE FATAL TO THE INFANT, THIS IS SEVERE ABRUPTION. AND IT'S ASSOCIATED WITH HEMORRHAGE AND SHOCK AND COAGULATING PROBLEMS IN THE MOTHER. SO, IT'S POTENTIALLY LIFE-THREATENING TO THE MOTHER AS WELL.

Q. AND CAN THAT BE CAUSED BY ONE USE OF COCAINE DURING PREGNANCY?

A. YES. YES. IT DOESN'T RELATE TO CHRONIC OR MUCH YOU USED IT OR HOW YOU TOOK IT, IT'S AN INDIVIDUAL RESPONSE THAT CAN BE CAUSED BY A SINGLE USE OF COCAINE.

Q. LET'S TALK ABOUT COCAINE FOR A MINUTE. FOR A CHILD IN UTERO, WHEN THE MOTHER INGESTED IT, WHAT DOES THAT DO TO THE LIFE SUPPORT FOR THE BABY?

A. WELL, THE DRUG IS—CAUSES CONSTRICTION OF BLOOD VESSELS. IT'S A VASAL CONSTRICTOR. WHEN YOUR BLOOD VESSEL CONSTRICTS YOUR BLOOD PRESSURE GOES UP, SO TWO THINGS ARE HAPPENING TO THE FETUS. FIRST OF ALL THE BLOOD SUPPLY TO THE PLACENTA AND TO THE BABY IS GOING TO BE REDUCED BECAUSE OF THE CONSTRICTION OF THE BLOOD VESSELS. ONE OF THE OTHER THINGS THAT IS ASSOCIATED WITH COCAINE USED IN PREGNANCY IS GROWTH RETARDATION, WHICH IS MORE OF A CHRONIC EFFECT, IT'S A BABY THAT HAS HAD RESTRICTIONS TO ITS BLOOD SUPPLY ON MULTIPLE OCCASIONS THROUGHOUT THE PREGNANCY.

Q. AND IF THAT HAPPENS WHEN THE CHILD'S ARM IS DEVELOPING OR HAND IS DEVELOPING, THE MOTHER USES COCAINE, WHAT CAN HAPPEN TO THE ARM?

MR. WHERRY: OBJECTION TO THE LEADING NATURE OF THE QUESTION.

Q. (BY MR. HOOD, CONTINUING) WHAT CAN HAPPEN TO THE ARM OR THE HAND?

A. WELL IT'S REPORTED BY SOME INVESTIGATORS THAT CONGENITAL ANOMALIES CAN BE ASSOCIATED WITH COCAINE INGESTION.

AND THE PROPOSED MECHANISM IS AT THE TIME OF FETAL DEVELOPMENT, THE FIRST 13 -- 12 OR 13 WEEKS OF PREGNANCY, IF AT THAT TIME THERE IS INTERRUPTION OF THE OXYGEN SUPPLY, IT INTERFERES WITH THE DEVELOPMENT OF THAT PARTICULAR ORGAN SYSTEM. AND THE EXAMPLE WAS AN ARM OR A LEG, BUT THERE ARE MANY--IT COULD HAPPEN TO ANY ORGAN SYSTEM.

AND PROBABLY THE ONE THAT I HAVE SEEN MOST FREQUENTLY RELATED TO COCAINE USE IS A DISRUPTION OF THE URINARY TRACT. THE DEVELOPMENT OF THE URINARY TRACT. SO THAT BLOCKAGE TO ESCAPE URINE AND WHATEVER ABNORMALITIES AND HOW THE KIDNEYS DEVELOP. SO, GOING BACK TO, THE QUESTION WAS, THE TWO EFFECTS THAT COCAINE HAS ON PREGNANCY IS TO CONSTRICT THE BLOOD VESSELS AND REDUCE SUPPLY OF OXYGEN AND NUTRIENTS TO THE BABY.

ALSO SECONDARY TO THAT, BLOOD PRESSURE GOES UP, AND THE PLACENTA IS REALLY A HUGE VASCULAR ORGAN, IT'S AN INTERMINGLING OF SMALL BLOOD VESSELS BETWEEN THE MOTHER AND THE BABY'S CIRCULATION. THE BLOOD DOESN'T ACTUALLY CROSS, BUT THE BABY'S VESSELS ARE VERY THIN WALLS, AND BLOOD AND OXYGEN AND NUTRIENTS AND THINGS DIFFUSE CIRCULATION BY THE MOTHER. IF ONE OF THOSE SMALL VESSELS RUPTURES AND BLEEDING OCCURRED, THAT CLOT, THAT BLEEDING WILL DISRUPT OTHER VESSELS AND CAUSE MORE BLEEDING AND

LEAD TO THE PLACENTAE ABRUPTION THAT I MENTIONED EARLIER.

Q OTHER CRITERIA UNDER THE POLICY WHICH WOULD MEAN THE MOTHER WOULD GET TESTED.

A. INTRAUTERINE FETAL DEATH OR STILLBIRTH, PREMATURE LABOR WHEN WE COULD FIND NO OTHER OBVIOUS CASE. FIRST INSTANCE, WOMEN WITH TWINS, HUGE RISK FACTOR. IF THAT PATIENT WOULD HAVE AN OBVIOUS CASE, URINARY TRACT INFECTION, IF THEY HAD BEEN IN A CAR ACCIDENT, THAT PATIENT WOULDN'T HAVE BEEN SCREENED, BUT SOMEBODY WHO HAD NO OTHER APPARENT REASON TO BE IN LABOR WOULD BE SOMEBODY THAT WE WOULD SCREEN. COCAINE HAS BEEN SHOWN TO STIMULATE UTERINE CONTRACTIONS, AND THE EXACT MECHANISM I DON'T THINK I CAN EXPLAIN.

Q. DEFINE THIS WORD PRE-TERM. PRE-TERM LABOR?

A. PRE-TERM LABOR IS ENTERING LABOR PRIOR TO 37 WEEKS GESTATION. WE SAY PREGNANCY LASTS 40—WOMEN ARE CONSIDERED TO BE AT TERM BETWEEN—BETWEEN 37 AND 42 WEEKS. ANYTHING LESS THAT 37 IS CONSIDERED PRE-TERM. OBVIOUSLY THE MORE PRE-TERM YOU ARE THE GREATER RISK OF BEING—

Q. IN OTHER WORDS, IF THE BABY COMES BEFORE 37 WEEKS?

A. YES, SIR.

Q. WHAT ARE WE DEALING WITH MEDICALLY?

A. WELL, IT WOULD DEPEND ON THE TIME AND GESTATION. A BABY BORN AT 36 WEARS IS GOING TO DO VIRTUALLY AS WELL AS A BABY BORN AT TERM. THEY MAY HAVE A LITTLE JAUNDICE, THEY MAY HAVE A LITTLE FEEDING PROBLEM, DIFFICULTY WITH TEMPERATURE REGULATION, BUT THEY'RE NOT GOING TO HAVE MAJOR COMPLICATIONS. A BABY BORN AT 24 WEEKS IS GOING TO DIE. MAYBE AFTER A LONG TIME IN THE NURSERY, BUT IT'S VERY UNLIKELY TO SURVIVE. WE SEE MORE PRE-TERM LABOR IN WOMEN BETWEEN 29 TO 31 WEEKS. IF YOU GRAPHED IT OUT, THAT'S WHEN MOST PRE-TERM LABOR SEEMS TO OCCUR. AND A BABY THAT IS DELIVERED AT 30 WEEKS GESTATION HAS AN 85 PERCENT CHANCE OF SURVIVAL. BUT THE MAJORITY OF THOSE BABIES WOULD GO TO THE INTENSIVE CARE UNIT, THE MAJORITY WOULD PROBABLY REQUIRE BEING ON A VENTILATOR FOR A VARIABLE PERIOD OF TIME. AND THEY WOULD BE AT RISK FOR OTHER COMPLICATIONS, WHICH ARE LESS FREQUENT BUT VERY SEVERE, SUCH AS INTRACRANIAL HEMORRHAGE, A BOWEL THAT BECOMES ISCHEMIC AND HAS TO BE REMOVED. INFECTION, JAUNDICE AND PROBLEMS SUCH AS THAT.

SO A BABY BORN AT 30 WEEKS GESTATIONAL, A RULE OF THUMB THAT WE USE WHEN WE ADVISE MOMS IS THE BABY WILL PROBABLY STAY IN YOUR TUMMY BEFORE IT

GOES HOME. SO 30 WEEK BABY YOU'RE LOOK AT PROBABLY SEVEN TO EIGHT MONTHS--

[Tr. 235, line 10 – tr. 236, line 2]

A. IN THE FORMULATION OF THIS POLICY WE DID GIVE CONSIDERATION TO FINANCIAL ISSUES IN TERMS OF OUR CONCERN OVER THE COSTS THAT COULD BE ENCOUNTERED IN TAKING CARE OF BABIES THAT WERE BORN PREMATURELY OR WITH OTHER--WITH MALFORMATIONS OR OTHER PROBLEMS THAT WOULD REQUIRE EITHER PROLONGED NEONATAL INTENSIVE CARE OR EVEN LONGER TERM CARE. IN DISCUSSIONS IN GENERAL WITH THE NEONATOLOGIST, WE, FROM LONG-STANDING, WE ARE AWARE OF THE VERY HIGH COSTS OF INTENSIVE CARE UNIT STAYS.

MR. WHERRY: I OBJECT TO THAT.

THE COURT: OBJECTION OVERRULED. YOU MAY PROCEED.

A. SPECIFIC NUMBERS AS TO THE COSTS OF VARIOUS SPECIFIC BABIES WHO MAY HAVE BEEN BORN DUE TO COCAINE INGESTION I COULD NOT TELL YOU. JUST AS EVIDENCE OF MY CONCERN OVER THE COST, I WOULD REFER TO THE LETTER THAT I SENT TO THE MICH COUNCIL THAT WE HAVE TALKED ABOUT EARLIER WHERE I POINTED OUT THAT I FELT THAT THE COST OF TAKING CARE OF THESE BABIES AND THE CONTINUING COSTS THAT MAY OCCUR WAS ONE REASON WHY

THIS STATE SHOULD HAVE AN INTEREST IN TRYING TO REDUCE THIS.

Testimony of William B. Pittard, M.D.
[Tr. 217, line 11 – tr. 218, line 14]

Q. COULD YOU DESCRIBE TO THE JURY THE MEDICAL NECESSITY OF WHY THIS WAS DONE? WHY THIS TEST WAS PERFORMED?

A. WHY IS IT PERFORMED? IT'S SORT OF LIKE MANY OF THE TESTS THAT YOU HAVE WHEN YOU GO TO YOUR PHYSICIAN FOR ANY PARTICULAR PROBLEM, THERE IS, FOR INSTANCE IN A CHILD WHO IS BEEN EXPOSED TO COCAINE IN UTERO, ONE OF THE MANY THINGS THAT YOU MIGHT SEE IS THE CHILD COULD BE UNDERGROWN OR HE COULD BE JUST NOT FEEDING VERY WELL. AND IN FACT THEY'RE VERY IRRITABLE ON OCCASION. ALL CHILDREN WHO ARE IRRITABLE ARE NOT EXPOSED TO COCAINE AND ALL CHILDREN WHO ARE EXPOSED TO COCAINE ARE NOT VERY IRRITABLE. SO IT'S A MATTER, YOU LOOK AT THE SERIES OF CLINICAL SYMPTOMS OF THE CHILD PRESENTS WITH AND THEN YOU WAY WHAT IS THE--WHAT IS THE DIFFERENTIAL DIAGNOSIS.

IN OTHER WORDS, WHAT ARE THE POSSIBILITIES THAT MIGHT EXPLAIN WHY THIS CHILD IS ACTING THE WAY HE OR SHE IS ACTING. WE'RE LOOKING AT A BABY THAT IS DOING SOMETHING ABNORMAL, OF COURSE. AND WITH THAT IN MIND, YOU MAY NARROW IT DOWN TO A SERIES OF LET'S SAY SIX OR SEVEN CRITERIA, NOT UNLIKE TRYING TO FIGURE OUT WHAT IS WRONG

WITH YOUR AUTOMOBILE IF THERE IS SOMETHING WRONG WITH IT AND THERE ARE SEVERAL THINGS THAT IT MIGHT BE, AND THEN YOU SAY THIS IS THE MOST LIKELY OR THESE ARE THE MOST LIKELY. AND THEN TRYING TO FIGURE OUT WHICH ONE OF THOSE SIX OR SEVEN POSSIBILITIES MIGHT BE CAUSING THIS CHILD TO ACT THIS WAY.

AND WITH THAT IN MIND, WOULD BE OF THE STUDIES YOU MIGHT DO, WOULD BE A URINE DRUG SCREEN SAYING THIS COULD BE EXPLAINED BY BEING EXPOSED TO DRUGS IN UTERO. WITH AN UNDERSTANDING OF WHAT IS WRONG, WE CAN THEN MUCH BETTER DEAL WITH HOW TO CORRECT IT.

Testimony of Thomas Rowland, M.D.
[Tr. 611, line 21 – tr. 612, line 10]

Q. AND AS AN OBSTETRICIAN, WHAT DID YOU SEE THE GOAL OF THIS POLICY BEING?

A. THE GOAL OF THIS POLICY WAS TO PREVENT THE DAMAGE TO THE FETUS AND TO EDUCATE AND HOPEFULLY REHABILITATE THE MOTHER. WE HAVE HEARD A LOT OF QUESTIONS ABOUT THE ALCOHOL AND TOBACCO ABUSE AND I WOULD ADMIT THAT THE ALCOHOL AND TOBACCO ABUSE ARE MORE COMMON, BUT THEY'RE ALSO NOT AS SEVERE. ALTHOUGH ALCOHOL ABUSE CAN BE VERY DAMAGING TO A CHILD IN A SEVERE ALCOHOLIC MOTHER, SOCIAL USE OF ALCOHOL MAY--MAY NOT HAVE ANY SIGNIFICANT EFFECT. AND YOU MAY HAVE VERY

LITTLE--LITTLE WAY TO DETERMINE HOW MUCH ALCOHOL A MOTHER IS DRINKING. COCAINE ON THE OTHER HAND CAN KILL YOU WITH ONE DOSE, ESPECIALLY CRACK COCAINE.

Q. AND THE BABY?

Q. AND THE BABY.

Testimony of Sarah E. Schuh
[Tr.290, lines 6-11]

A. THAT WE WERE SEEING AN INCREASE IN PROBLEMS IN OUR PREGNANCIES WITHIN THE UNIVERSITY THAT RELATED TO THINGS THAT HAD BEEN DESCRIBED AS ATTRIBUTED TO COCAINE IN THE PAST. AND MY UNDERSTANDING FROM MY PRIOR WORK WAS, AND I THINK MOST OF THE CURRENT LITERATURE AT THAT TIME DID NOT INDICATE MARKEDLY INCREASED RISK TO THE FETUS FROM OTHER DRUGS OF ABUSE.

Joint Exhibit # 12

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The hospital and attending physician are authorized to release any medical information required in the processing of applications for financial coverage for services rendered this admission. I permit a copy of this authorization to be used in place of the original. I certify that the information given by me in applying for payment under Title XVIII of the Social

Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges for the physician(s) for whom the hospital is authorized to bill in connection with its services.

"I authorize any holder of medical or other information about me to release to the Social Security Administration and Heath Care Financing Administration or its intermediaries or carriers, Department of Social Services or its contractor, Blue Cross and Blue Shield and South Carolina, Champus and it's agents and to the billing agent of this physician or supplier, which is the Professional Staff Office, any information needed for this or a related Medicare, Medicaid, Champus or Blue Shield claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment"

I request that payment of authorized benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to OCHAMPUS and its agents any information needed to determine these benefits or the benefits payable for related services.

This also applies to any commercial insurance.

ASSIGNMENT OF INSURANCE BENEFITS.

I/we hereby assign all my rights under any policy of insurance to my attending physician and the Medical University Hospital including, but not limited to, major medical insurance, hospital benefits, sick benefits, injury

benefits due to me because of liability of a third party, such as auto insurance, workman's compensation insurance, and/or minimum medical hospital and disability payments commonly referred to as "PIP" pursuant to Section 56-11-1110, S.C. Code of Laws, 1976, as amended and the proceeds of all claims resulting from the liability of the third party payable to an person, employer, insurance company to or for the patient, up to the full amount of the hospital bill. in addition, I/we further warrant and represent that any insurance that we assign is valid insurance and in effect and that I/we have the right to make this assignment.

PERSONAL LIABILITY

I expressly understand that I am personally responsible for the entire hospital and physician charges resulting from my care and treatment. Any payment received by the Medical University as a result of the above Authorization for Release of Medical Information and Assignment of Insurance Benefits will be credited toward my account, and I will be personally liable for any and all remaining balance on my hospital or physician account.

AND CONSENT FOR MEDICAL TREATMENT

"I acknowledge that I am suffering from a condition requirin Medical/Hospital care and thereby voluntarily consent to such Medical/Hospital care encompassing diagnostic procedures and medical treatment by my physicians, assistants, or assignees, as may be necessary in his or her judgment. I further consent to the testing for infectious diseases such as, but not limited to syphilis, hepatitis, and AIDS and I further consent to the testing of drugs if deemed advisable by my physician. I am aware that the practice of medicine and surgery is not an exact science and I

acknowledge that no guarantee has been made as to the result of treatments or examinations. I have read or had had read to me this consent and I voluntarily certify that I understand and agree to its contents"

VALUABLE RELEASE FORM

I have been requested to check my valuables wit the hospital and hereby release the Medical University Hospital of any liability and assume responsibility myself for any items not deposited to the hospital's care. Any valuables not claimed with thirty (30) days of discharge will become the property of the Medical University Hospital.

By signing below, the undersigned certify that the foregoing paragraphs have been read and in full and explained to the undersigned

Signature of patient

Signature of patient or legal guardian in case of minor	Signature of guarantor (if different from patient) ADDRESS:
Date/Time signed	Witness signature

Joint Exhibit 13

CONSENT FOR TREATMENT
MUSC MEDICAL CENTER
AMBULATORY CARE

Patient: _____
Date of Birth: _____
Date: _____

I, __[patient's name/authorized person]__, hereby authorize the administration of medical treatment(s) and the performance of medical procedure(s) while __[patient's name]__ is a patient of the Medical University Clinics.

I understand that such treatment(s) and procedures(s) will be performed by attending physicians, members of House Staff, hospital employees and/or supervised students. The intention hereof is to grant full authority to such physicians and surgeons and the Medical University Clinics, their respective employees and assistants, and supervised students, to administer and perform all and singular any drugs, treatments, tests or diagnostic procedures, including the testing for infectious diseases such as but not limited to, Syphilis, Hepatitis, and AIDS. I further consent to the testing for drugs if deemed advisable by or necessary in the professional judgment of the physician or surgeon, or a physician or surgeon acting under their instructions. Attending physicians, members of House Staff, and the Medical University Clinics have my permission to reveal information to appropriate agencies and individuals where it because necessary to protect the welfare of myself/the patent and/or the community. I consent to and authorize the above to or upon me, or the person for who I am authorized to consent.

The Medical University of South Carolina is authorized to furnish requested information or excerpts to the referring physicians, if any, and to any insurance company or authorized third party payor for the purpose of obtaining payment of the account of the Medical University of South Carolina or any physician for services provided to the patient. I expressly agree to be personally responsible for any portion of the account which is not paid by a third party payor.

I hereby certify that I have read and understand the above authorization, that inappropriate paragraphs, if any, were stricken before I affixed my signature and no guarantees or assurances have been made as to the results of treatment(s) and procedure(s)

DATE: _____ By:_____
(Patient or authorized person)
If not patient, then state patient's name and relationship

WITNESS: _____ _____
Patient's Name

_____
Relationship to Patient.

Plaintiffs' Exhibit # 105

December 13, 1990

State Council on Maternal Infant
And Child Heath

Dear Sirs:

Thank you very much for the opportunity to present to you some of my feelings on the very important issue of drug abuse in pregnancy. I apologize for not being able to present this to you in person; however I was unable to extricate myself from other responsibilities.

As you have already identified in your position paper, intrauterine drug abuse is a significant contributor to our escalating toll of fetal, neonatal and childhood morbidity and mortality. The cost to society of supporting these damaged citizens and absorbing their lost productivity is a significant impetus to the state taking action in this regard even if the harm to the individual were not considered.

I believe the major deficiency of this position paper is its failure to recognize the possibility for positive cooperation between both the medical profession and governmental authorities. The position paper suggests there is an either/or situation where criminal prosecution would be used as a substitute for effective prenatal services. Obviously, it is essential that adequate preconceptual and prenatal care be provided including an increased accessibility to substance abuse treatment facilities. Unfortunately, it has been our experience that efforts at approaching this on a purely medical basis have not been successful as many of the patients in greater need of assistance are completely outside

the medical loop. It has been our experience that despite patent education, counseling and voluntary referral for substance abuse treatment, the actual number of women who have taken advantage of this opportunity is minimal. However, the cooperative effort of the concerned police force, a conscientious but thoroughly professional solicitor's office, and the judiciary has significantly improved the ability of the medical profession to make a positive impact. The involvement of the criminal process system has allowed us the leverage to firmly but fairly apply the power of the state to insist that substance abusing woman avail herself to prenatal care, substance abuse treatment, and social service whiles at the same time maintaining the ability to protect the community, the infant and the unborn from the continuing abuse if treatment fails. Our preliminary efforts with this approach appear to have been successful and I am sure that this information will be outline for you in detail by the other participants in this conference.

I would like to strongly point out that there is no evidence that this approach has driven any patients away from prenatal care as is popularly asserted. This is a major criticism addressed to such approached which are frequently misinterpreted as being "punitive"; however, this assertion is unproven. Our own data does not demonstrate any change in the utilization patterns of our prenatal clinics nor have we identified any increase in unbooked deliveries at other regional hospitals. Our own experience suggests that a zero tolerance approach to drug abuse during pregnancy supported by the police and judicial system has had a chilling effect on the social or casual use of drugs during pregnancy, particularly cocaine. As will be demonstrated to you in date from our experience at the Medical University, the incidence of positive testing for cocaine during pregnancy has consistently fallen despite an increased

frequency of testing from the time that this program was instituted.

It is widely known that the failure to avail oneself of prenatal care is very typical of the seriously substance addicted patent. There is very little opportunity to impact of this pregnancy as these patients because they do not make themselves available for identification. It is therefore most important that these people not be allowed to slip away from intervention as has been the case almost uniformly in the past. Failure to effetely intervene, often the index pregnancy allows this destructive behavior to repeat itself from pregnancy to pregnancy. Through the threat of prosecution, we have been able to insist upon these women receiving substance abuse treatment available in our community. The involvement of the legal system also requires the involvement of child protective services. While it is agreed that the "ultimate goal should be to protect the integrity of the family." It should also be the role of the state to protect the safety of the infant in the dysfunctional family. From a sociological perspective, there is probably no greater role for either the medical profession or the state than to intervene effectively to prevent the abuse of children which leads unfortunately to the creation of abusive and dysfunctional adults.

The popular characterization of the approach which we have taken is that it is "punitive". However, I think this is a significant misconception. While this may be considered a coercive approach, the ultimate goals are to rehabilitate the adult who is currently abusing illegal substances, prevent needless prenatal morbidity and mortality, and protect infants and children from abuse and social neglect. If this program can be shown to be effective in achieving these

goals, then I think it is probably as far from the concept of punitive as is possible.

As physician and medical advisor, I have been significantly troubled by the consideration that this program violates the physician-patient relationship and patient confidentiality. I agree that this violation is inherent in the reporting of drug abuse by pregnant women. However, with the continuing erosion of the physician-patient relationship which is evident in may ways, this may be a moot point. At the present time, patients cannot be admitted to the hospital without getting pre-authorization from either federal, state, or private agencies regarding the indications for said admission. A similar situation exists if complications develop requiring reconsultation with public or private payers to justify the extension of hospitalization. As its essence, this is probably the most basic violation of the physician-patient relationship where medical decisions to treat or not treat and the specifics of individuals cases must be reviewed by outside non-medical consultants for their approval. Additionally, the legal system has dissected the concept of doctor-patient relationship in the pursuit of discovery, and the legislature has enacted laws which redefine this relationship to meet other societal needs. Most importantly would be the laws requiring the reporting of evidence of child abuse as an excellent example of how societal needs to protect the defenseless assumes greater importance than the concept of the doctor-patient relationship and the confidentiality. AS you are aware, the reporting of such child abuse is considered mandatory under South Carolina state law.

As a specialist in maternal-fetal medicine, I am constantly confronted with situations that required compromise to protect both the mother and the fetus. My responsibility is to provide the fetus with the best possible environment while at

the same time maintaining the health and autonomy of the mother. Frequently, the needs of the fetus come into conflict with maternal autonomy and at those times, significant ethical decisions must be made. I am of the strong opinion that the third trimester fetus deserves legal stand comparable with the fact that it is a potentially viable human being and is worth of protection of this or her life or health is in jeopardy . When such jeopardy clearly exists as it does with the situation of maternal substance abuse during pregnancy, then the ultimate benefits to both the individual fetus and to society as a whole seems to outweigh the potential deterioration to the physician-patient relationship, maternal confidentiality, and the legal rights of the mother especially considering her involvement in an already defined illegal activity. As a maternal fetal medicine specialty, I do not have the option of viewing this topic in any other way because my career is wholly involved in trying to maximize the outcome of pregnancy for both the mother and the infant.

I do not pretend to be either a lawyer, philosopher or ethicist. I prefer to consider myself as being practical. WE have attempted to address the drug problem in pregnancy by education, identification, counseling and referral for voluntary substance abuse treatment. This has not been successful to any degree and unfortunately, I believe that this position paper does little to improve the status quo and will therefore not effectively intervene in this escalating problem. In fact by accepting this more passive approach to intervention, we may indeed be sending the wrong message for a large number of the casual users of drugs such as cocaine regarding the importance of substance abuse during pregnancy. I emphasize again that our more aggressive approach should be considered very preliminary but does appear to be effective in preventing substance abuse, allowing for better rehabilitation of the substance abusing

mother, and in better protecting the infant at risk. It is critical that more extensive and effective preconceptual and prenatal educated be instituted regarding the risk of drug abuse in pregnancy. Additionally, our state as many others, has an insufficiency of affordable and effective treatment services for the drug abusing mother. However, using the legitimate power of the state to intervene following the commission of an illegal act to compel and supervise the compliance of these individuals with prescribed treatments plans as deemed necessary by the medical advisors seems to be the best opportunity at present to reduce the relevance of substance abuse during pregnancy, enhance the rehabilitative possibilities for the mother, and most importantly, protect the infant and break the cycle of abuse. I urge you consider the continued evaluation of this approach.

I apologize for the rambling nature of this letter. Admittedly, it was put together somewhat hastily, but I do appreciate your consideration of it. I would encourage you to look beyond the position paper which was presented tome and consider the possibility that the conscientious, concerned, and fair cooperation between the medical profession and the legal authority of the state may provide the opportunity for both a compassionate and effective intervention to reduce the emotional, physical, and socials costs of drug abuse during pregnancy.

Sincerely,

/s
Roger B. Newman, M.D.
Associate Professor of Obstetrics and Gynecology/Director of Maternal-Fetal Medicine

RBN/fwm

Defendants' Exhibit # 133

1991 South Carolina Prevalence Study of Drug Use Among Women Giving Birth

EXECUTIVE SUMMARY

PURPOSE: The State Council on Maternal, Infant and Child Health (MICH), through its Substance Abuse Committee, commissioned this study to estimate the number and percentage of women giving birth in this state who use alcohol, illegal drugs and non-prescribed drugs and to describe the women who use them.

METHODS: Anonymous urine specimens were collected from women giving birth in 24 hospitals and anonymous meconium specimens were collected from newborns in 3 hospitals over a six week period between November 1990 to April 1991. The 24 hospitals were selected in such a way as to represent all women delivering in South Carolina community hospitals. The responses rates were 89.7% and 66.4% respectively.

Alcohol and drugs can be detected in urine for uop to 7 days and in meconium, an infant's first stool, for up to six weeks. Urine and meconium samples were tested for the presence of the following 11 drugs:

Alcohol
Amphetamines (Speed)
Barbiturates (sleeping bills Seconal (R), etc)
Benzodiazepines (Valium (R),
Marijuana
Methaqualone (Quaaludes (R))
Methadone
Opiates
Phencyclidine (PCP)

Tranquilizers, etc) *Propoxyphene (darvon ®)*
Cocaine

MAJOR FINDINGS:

Overall

- Over 15,000 infants are born each year in South Carolina to mothers who use alcohol, illegal drugs or non-prescribed drugs. This represents roughly 1 in 4 infants born each year.

- 12.1% of delivering women statewide used alcohol and drugs based on urine testing (short detection period), 22.4% based on meconium testing (longer detection period), and 25.8% based on both testing methods.

- South Carolina is the first state in the nation to complete a prevalence study of this size, nature, and quality. Therefore, it is difficult to directly compare ourselves to other places. Published studies suggest that the use of cocaine and marijuana by delivering women in this State may be lower than other places while the use of barbiturates and opiates may be higher.

- The problem of alcohol and drug use among women giving birth is not limited to any one group of women or one place. The percentage of women using alcohol and drugs varies by type of drug, geographic location, and characteristics of the women.

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Cocaine

- As many as 3,221 delivering women statewide (5.8%) use cocaine each year based on urine and meconium testing.

- Black women are nearly 6 times more likely to use cocaine than white women based on urine testing.

- Women whose intended payment source is other than commercial insurance (i.e., Medicaid and Other defined sources) are 17-18 times more likely to use cocaine than women with commercial insurance based on urine testing.

- Cocaine use is also higher among women delivering in urban hospitals than rural hospitals based on urine testing.

I. Introduction

I.A. STUDY BACKGROUND

This prevalence study has been conducted under the auspices of the State Council on Maternal, Infant and Child Health (MICH Council). The MICH Council was created in 1986 by the South Carolina General Assembly to improve the planning and coordination of maternal, infant and child health services. The MICH Council, as a collaborative effort of the public and private sector, includes the commissioners of State health, human services, and education agencies; legislators; representatives of medical schools, school of public health, health care providers and voluntary organizations; and gubernatorial appointees. The MICH Council is staffed by the Governor's Office.

The MICH Council created the Substance Abuse Committee in December 1989 to study the problem of maternal substance abuse and its impact on infants and child, and to develop policy and program recommendations for the MICH Council. The Committee identified the need to know, as accurately as possible, the prevalence of maternal substance abuse in South Carolina. The Committee also initiated efforts to study effective prevention and treatment interventions as well as ethical and legal issues raised by this problem. The work of the Substance Abuse Committee has been accomplished through three subcommittee focusing on 1) prevalence, 2) prevention and treatment, and 3) ethical and legal issues.

The Prevalence Subcommittee coordinated the design and implementation of the prevalence survey. Funding for the study was achieved through contributions of several State and private agencies. Scientific direction was also provided by representatives from several agencies. The entire effort has required interagency and interdisciplinary coordination, and efforts on the part of may individuals and agencies.

I.B. CONSEQUENCES OF DRUG USE DURING PREGNANCY

The use of alcohol and other drugs during pregnancy can have serious consequences for the health of the baby, the health of the mother, and the health of our society.

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- *Cocaine Use* during pregnancy is associated with an increased risk of sudden infant death syndrome, low birth weight, seizures, stroke, heart attacks, lack of bonding, emotional disorders, behavioral problems and learning disabilities among infants.

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The maternal effects of alcohol and other drug use also include increased risk of premature delivery, increased risk of premature separation of the placenta, and increased risk of spontaneous abortion.

Women who use alcohol and other drugs during pregnancy are more likely to have other poor health behaviors such as smoking cigarettes. Poor nutrition and inadequate weight gain during pregnancy are also a result. Such mothers are more likely to have inadequate prenatal care, start prenatal care later, or have no prenatal care at all. Mothers who use alcohol and other drugs are also at a higher risk for hepatitis and sexually transmitted diseases, such as syphilis and HIV infection.

The societal costs of maternal drug use are staggering:

- Premature and low birth weight births caused by drug exposure are associated with increased need for neonatal intensive care (NICU) at birth.
- Drug-exposed infants are more likely to need socials services and are more likely to enter the foster care system.
- Infants exposed to alcohol and other drugs during pregnancy are more likely to need special education services.
- These infants are less likely to achieve educational or occupational goals that otherwise might have been possible.
- Drug exposure is also associated with family stress and reduced bonding between mother and child

The excess medical cost associated with affected drug-exposed infants can easily exceed $50,000 per infant in the first year of life alone. The lifetime economic cost associated with the severe effects of drug exposure can exceed $1 million per infant.

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IV. Discussion

Historically, South Carolina has enjoyed a cooperative atmosphere in addressing health issues among State agencies, health care providers, and voluntary health organizations. The complexity and design of this study necessitated that all participants work closely to design, implement and monitor the project. Because of cooperative history among participating organizations, the demands generated by the magnitude of this study were addressed in a timely manner resulting in this quality study.

Although drug use can be a criminal activity and drug use during pregnancy raises many ethical, legal and social questions, this prevalence study went beyond these issues and represents a major step towards accurately defining the problem of drug use during pregnancy in South Carolina. The study is representative of all women giving birth in South Carolina: both insured and Medicaid, young and old, black and white, rural and urban, Piedmont and Low Country. Using a conservative definition for the calculation of a response rate, the overall response rate was 90% with over 80% response rate among all groups. The study's high response rate and representativeness strongly support the accuracy of the study's prevalence estimates.

With over 3,7000 urine specimens, this study also has the statistical power to reliably define the magnitude of the problem statewide and describe the women using alcohol and drugs during pregnancy. This study represents the largest population-based study of drug use among women giving birth using one common laboratory and has one of the highest response rates for this type of study. Many of the study findings are statistically significant at a p-value less than 0.05 which strongly supports that these differences are real and less likely to be due to the number of women tested. In fact, one needs to be cautious in using findings that are not statistically significant for policy and program development. For example, very few study women reported that their main intended payment was self-pay. Therefore, it is difficult to interpret the findings related to this group because a few more women testing positive or negative could substantially alter findings. This problem is especially true when examining detailed tables for each of the reasons. Again, because of the size of this study, many of the important finds can be stated more confidently.

IV.A. NUMBER OF DRUG-EXPOSED INFANTS

This study estimates that thousands of infants are being born each year in South Carolina to mothers who used alcohol, illegal drugs or non-prescribed drugs near the time of delivery (See Table X). By multiplying the number of 1990 South Carolina births to South Carolina residents based on birth certificates by the prevalence of material drug use based on urine testing, as few as 107 infants are exposed to Darvon (R) or propoxyphene near the time of delivery to as many as 2,974 to barbiturates (See Table IX). Over 1,000 infants are exposed to the recent use of marijuana, opiates and alcohol; 422 infants exposed to cocaine.

The actual number of drug-exposed infants may be even higher than estimates based on urine testing. Using a combined prevalence to urine prevalence ratio based on the prevalence in Table V (combined prevalence divided by urine prevalence) and multiplying by the number of exposed infants based on urine testing in Table X, over 15,000 infants infants are exposed to alcohol and drugs. Approximately 4,500 infants this year will be exposed to barbiturates and marijuana. Roughly 3,000 infants will be exposed to cocaine and opiates.

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Testimony of David Schwacke
[Tr. 159, lines 1-10]

Q. AND IF THEY DID WHAT THE POLICY REQUIRED, DID YOUR OFFICE PROSECUTE THEM IF THEY WERE TO SUBSTANCE ABUSE LIKE THEY WERE SUPPOSED TO?

A. IF THEY DID THE PROGRAM REQUIREMENTS, ATTENDING COUNSELING, ATTENDING THE PRISON TOUR, WHATEVER WAS REQUIRED OF THEM, THOSE CHARGES WERE DISMISSED AND THEY WERE ABLE TO EXPUNGE THEIR RECORD.

Q. WE HAD 253 THAT WERE TESTED POSITIVE, 30 WERE ARRESTED AND TWO WERE PROSECUTED. DID THOSE TWO ACTUALLY EVER GET SENTENCED TO JAIL?

[Tr. 159, line 22 – tr. 160, line 7]

Q. (BY MR. HOOD, CONTINUING) THE TWO WOMEN THAT CAME UNDER THE POLICY, WERE THEY EVER ACTUALLY PUT IN PRISON AND SENTENCED?

A. THEY WERE NOT SENTENCED TO ACTIVE JAIL TIME, THEY WERE PLACED ON PROBATION. CONTINUED DRUG TREATMENT WAS A SPECIAL CONDITION ON THEIR PROBATION.

Q. AND THE THIRTY WOMEN THAT WERE ARRESTED, DID ANY OF THEM EVER GET PLACED IN JAIL OTHER THAN THE INITIAL ARREST, WHERE THEY SENTENCED AND CONVICTED AND PUT IN JAIL FOR VIOLATING THE LAW?

A. NO, THEY WERE NOT. NOT--NOT RELATED TO THESE OFFENSES.